

THE MEDICAL JOURNAL OF AUSTRALIA

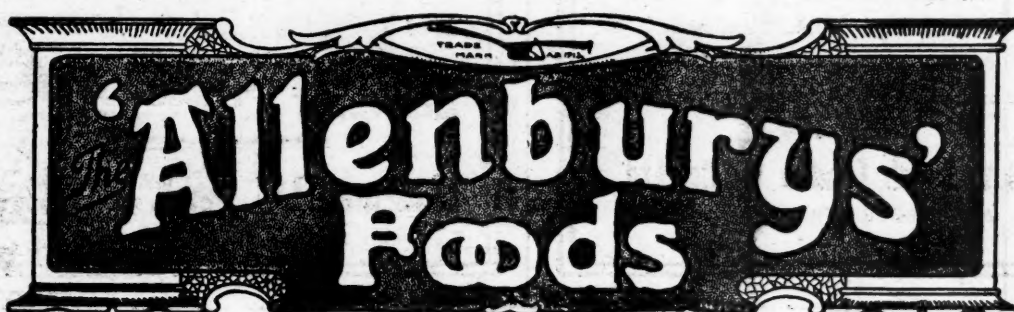
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The Journal of the Australian Branches of the British Medical Association.

VOL. I.—4TH YEAR—No. 19.

SYDNEY: SATURDAY, MAY 12, 1917.

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TO THE MEDICAL PROFESSION.

We beg to state that we have received a limited number of the Ephemeris Pharmacologica for 1917 issued by Messrs. Oppenheimer, Son & Co., Ltd., London, and shall be glad to hear from any member of the Medical Profession who has not received one, and who wishes a copy, which will be sent post free.

It is a matter of regret that the necessity of keeping this Medical Diary and Visiting List a suitable size for the pocket, renders it impossible to incorporate more than a terse synopsis of the more recent publications relating to drugs. We venture to hope, however, that the 1917 edition will meet with an equally cordial reception as previous editions, and that members of the Profession will continue to favour us with suggestions for the improvement of this miniature publication.

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No. 19.

PERSONAL EXPERIENCES AND CLINICAL OBSERVATIONS WITH THE THIRD AUSTRALIAN GENERAL HOSPITAL, LEMNOS AND EGYPT.¹

By Herbert J. Stewart, M.D., B.S. (Edin.),
Brisbane.

You have already listened to the story of the sojourn of the above Hospital from Australia to Lemnos, and possibly also back to Egypt, coupled with the humorous incidents happening on the way, by Dr. Gibson, in his paper read at a meeting of the Branch of the Association some time back. In that paper, although I did not have the pleasure of hearing it read, I believe the speaker confined his remarks specially to the ophthalmic side of the work—a department in which, as you all know, he himself is peculiarly interested. It is my intention this evening to confine my remarks to the medical aspect of the Hospital, and, in doing so, I refrain from entering into much detail, but will endeavour to give you a general idea of the diseases met with at Lemnos and Egypt, and, in as broad a manner as possible, to try to outline the routine methods of treatment carried out in each particular case.

Our equipment completed, and assured of the fact that when we arrived at Lemnos an already established hospital would be awaiting us, we left London with gladdened hearts at the prospect of our base of operations being placed near our own fighting boys. The thoughts of a sojourn in France soon vanished from our minds, and all were agreed that for a considerable part of the war, if not during all of it, our field of operations as a hospital would be confined to the Orient.

I marvel yet at our wonderful escape from submarine attack on our voyage out, for we all would have been in "Davey Jones' cabin" by now, if such an unfortunate affair happened. But it was not to be. At various ports of call, such as Malta, Alexandria, we found the hospitals contained many of our wounded and sick lads. They seemed to be well scattered throughout the Mediterranean, and many were on their way home to England.

From Alexandria, our last port of call, we set sail for Lemnos through the beautiful Aegean Isles. No event of any importance happened during the last part of our journey, and on a glorious Monday morning (July 26, 1915) we arrived at our destination—Mudros, Lemnos.

Like practically all the Orient, Lemnos is as treeless as the Sahara, except where small homesteads and villages are placed; fig trees, occasional orange and lemon, mulberry and vineyards are the only adornment. That it is a land which at certain months of the year flows with milk and honey goes without saying, as the beauties of the island in the ideal spring were told by the members of our first regiments to land there. All we could see on our arrival

was the ubiquitous Scotch thistle, and they, for the most part, were dead, and exhibited the same glorious Scotch independence and resentment as did their forefathers of old to anyone who approached or sat down upon them incautiously. The climate, we were told, was all that could be desired, except the middle of the day, which was inclined to be somewhat tropical. This we soon found out to be the case; but who, I ask, could forget those glorious mornings and evenings, accompanied by those unsurpassed sunrises and sunsets, which we were daily treated to during the greater part of our sojourn in the island?

Our good ship safely anchored in the middle harbour of Mudros; it was not long before we were obliged to regard war promises as the old story of the piecrust—"made to be broken." There was no hospital prepared for us, and not even a hospital site delineated. No one seemed to know who we were, or what intentions we had in coming to Lemnos. We were not expected, and almost regarded as intruders. A glorious and enthusiastic introduction to our future field of work! Little did the authorities know that we had a leader of indomitable courage on board, and, his presence and intentions made known to them, we were ordered to remain on our ship till preparations were made for our landing. Now it was during the period of quiescence, if one may term it that, that many officers made use of their time in visiting the hospitals on the east side of the harbour and acquainting themselves with the various endemic and epidemic diseases that were being treated at that time. It was also during our visit to these hospitals that we received a fair introduction into the fly pest—an invasion to be seen to be appreciated.

Our first impressions of the hospitals on the Eastern Harbour, their site and surroundings, did not give a favourable outlook as regards successful results in our future work. Their position received the full blaze of the midday and westerly sun, and was very hot. All the roads leading to the hospitals were terribly cut up by motor and mule traffic, and in parts were ankle deep in dust. The weather at this period was very dry, and whenever a breeze of any velocity sprang up, all the hospital areas received the full benefit of the dust. Hence it was with the combination of dust and flies that sepsis was fairly rampant, and subsequently operative work became curtailed. The condition and comfort of most of these hospital tents left a good deal to be desired. In many of them there were no beds, and patients were obliged to lie on ground sheets and blankets, while the more acutely ill were provided with mattresses and beds, where possible.

From the medical aspect, cases of gastritis, enteritis and entero-colitis were the chief source of medical anxiety. I am speaking now of the end of July and the early part of August. The difficulty in attending to the unfortunate individuals, owing to the lack

¹ Read at a Meeting of the Queensland Branch of the British Medical Association on April 13, 1917.

of proper hospital appliances, such as bed pans, etc., and to the restricted orderly staff, was quite apparent to a visitor, and in many instances patients with violent intestinal tenesmus and with frequent bloody motions, and those suffering great weakness and emaciation, even crawled to the latrines as best they could, in order to get to a spot where they could easily relieve themselves of their constant irritation.

Now you will notice that I do not classify these cases under the heading of dysentery, for the simple reason that the real pathological nature of the complaint was at that time not understood, although the belief of specific infection was still kept in mind by medical officers in charge. If a pathological department did exist at that time in the eastern side, it must have been on a very small scale.

Enteric fever was also prevalent, and there is no doubt that some of these gastro-enteritis cases at this period may have been pathologically undiagnosed paratyphoid conditions.

Other ailments, such as bronchitis, pneumonia, rheumatism, pleurisy, irritable hearts, jaundice, etc., were also under treatment. A few exanthems were also under observation.

Of venereal trouble—*ça va sans dire*.

In reference to the gastro-enteritis and enterocolitis cases, the treatment meted out to the patients consisted of (1) dietetic, and (2) eliminative methods. There was no specific treatment given at this time.

Now this only stands to reason, for, as I have before stated, the true pathological nature of these complaints was not properly understood. You will see later that our own Hospital worked in the same darkness for a considerable time, till we had our Pathological Department under the most capable management of Professor Charles J. Martin in full working order. I do not for one moment suggest that some, if not the majority, of the cases were not gastro-entero-colitis cases due to dietetic errors, exposure, and other excesses; but the fact remains, to my mind, that a good many of them were due to specific infection, amœbic and possibly paratyphoid, for it did not take our own Pathological Department long to discover the true nature of infection of these cases, with the excellent therapeutical and statistical results that followed treatment. From the dietetic point of view, the usual routine in these gastro-entero-colitis cases was carried out. These patients were placed on a water (boiled) diet, and possibly in the less severe cases barley and rice water for a period of 24 to 48 hours or longer. As the cases improved, the diet changed, through milk to broths and a light diet. Herein were the hospitals greatly handicapped through the lack of fresh foodstuffs, for in nearly all cases tinned food and condensed milk (in a good many cases of questionable quality) were what was supplied.

Medicinal Treatment.—In this department the want of a true pathological understanding could not fail to appeal to the observant mind. I would not be wrong in saying, I believe, that all these patients, on admission to hospital, had the usual hospital eliminative methods applied to them, such as magnesium

sulphate, sodium sulphate, calomel or *oleum ricini*, etc., followed by the usual astringent methods, as *mistura cretæ* and sedatives of bismuth, etc., with or without opium. I know from personal observation that *mistura cretæ* was administered in practically every gastro-entero-colitis case I saw. The diagnoses gastro-enteritis and dysentery were frequently made. That was good as far as a provisional diagnosis was concerned. In a good many cases under the aforesaid treatment improvement, and even convalescence, was obtained; but I am sure relapses and fatalities were of no mean number. In the more intractable cases resource had to be given to astringent injections, such as silver nitrate, tannic acid, and potassium permanganate, the latter drug given both internally and as an enema.

To sum up the eastern hospitals at Mudros, every credit is due to these units for their devotion to duty whilst working under most trying difficulties. That their labour would have been materially helped by an up-to-date pathological department goes without saying, and the marvel is they obtained such remarkably good results, therapeutically and statistically, from the contents of a hospital pannier. Nevertheless, the shortcomings of these hospitals were a warning and a stimulus to the 3rd Australian General Hospital; but the fact remains that the profession of Australia will look with pride on these early hospitals, over-worked, under-staffed, etc., when the history of the Gallipoli campaign is written.

Amœbic Dysentery.

Now, to come nearer home, we will take it that the 3rd Australian General Hospital is already established on Western Mudros, and every department in full working order; for to give you the humorous side of our initial stages, and the difficulties we had to overcome with regard to tents and other accommodation, would take up too much of your time. Probably Dr. Gibson may have enlightened you upon that aspect. Now to apply our eastern observations and deductions to our western experiences, as I have stated before, we were almost immediately confronted with the gastro-entero-colitis cases, and worked in the same darkness as did our brethren on the Eastern Harbour. We found that the eliminative methods of treatment were a success, in as far as ameliorating the symptoms was concerned, but not in many cases giving a definite and permanent cure. I speak from personal experience, for I had the good fortune to have great numbers of these cases under my observation and treatment in the initial stages of our hospital work. I even went so far as to segregate a whole tent of patients, and to place each section under different eliminative treatment. The drugs that gave the most satisfactory results were the combination of magnesium sulphate and calomel.¹ Of course, the diet was attended to as well. But this gave no satisfaction, for many cases in which convalescence had apparently been reached soon relapsed. These constant disappointments soon determined the fact that we had a specific infection to treat, and herein lay the absolute and indispens-

¹ "Dysentery Carriers," by Kennedy and Rosewarne, *British Medical Journal*, December 23, 1916.

able value of pathological aid. The stools of these patients were frequent and blood-stained. Every patient who was subsequently admitted with symptoms of entero-colitis had his stools forwarded to the Pathological Department for examination, and it was quickly discovered that we were dealing in the majority of cases with an acute amœbic infection of the intestinal tract. Therefore it became legitimate for us to classify these cases under the heading dysentery, denoting a specific disease, due to a specific organism—the amœba.

Naturally enough, the treatment had to be altered accordingly. Knowing full well the specific action of emetin, the active ingredient of *ipecacuanha radix* on the *amoeba dysenterica*, as definitely shown by leading authorities on Eastern epidemics of this disease, this drug was immediately put to use. At first it was advised to inject the drug subcutaneously in doses of two-thirds of a grain daily, as a prophylactic to those who were exposed to infection, and showing very early and slight signs of intestinal trouble, and twice daily to those who were really affected. After three or four days' treatment the beneficial effect was quite marked. The stools lessened in frequency, the blood ceased, and general all-round improvement followed. Elimination, bowel irrigation, and dietetic treatment was carried out at the same time. The emetin treatment was carried out for a week, and relinquished for three or four days, and again resumed. After the patients became convalescent, with normal stools and good appetite, these injections were still continued once a day for about a week or more. It was my experience to find that a larger dose of one grain subcutaneously daily, necessitating less puncturing of the skin, produced more rapid and lasting results. It was the custom in the intervals of subcutaneous injection to administer the drug in powder form, as a pill coated with salol, in doses varying from 20, 30 and 40 grains at one time. It became a noticeable feature that the large subcutaneous injections of a grain of emetin produced no emetic effect, as compared with the powder form, following which emesis was a common feature. This was obviated in the majority of cases by the previous administration of alcohol in the form of whisky, or the combination of tannic acid (1 part in 3) with the drug. But in practically all cases emesis followed. Tannic acid, in the strength of a 2% solution, was used as a rectal injection, having both an astringent and slight amœbicidal action, with good results. Potassium permanganate was also frequently used, and had a desired soothing and cleansing effect.

Now it followed that, with a definite ætiological and pathological knowledge and a definite specific treatment, our success with these cases was most gratifying, and in no instance, either in Lemnos or in Egypt, to my knowledge, had we the misfortune to meet with any of those unfortunate and severe sequelæ—liver, lung, or cerebral abscesses. I would emphatically state the utmost importance of early pathological diagnosis and early treatment. It is the neglected and undiagnosed cases that are usually followed by sequelæ, especially in those persons who are "carriers" in the true sense of the word and

show no signs of intestinal derangement or any untoward signs of amœbic infection at all. These cases, unfortunately, are not uncommon—a very important point for us as a profession in Australia to bear in mind.

Thus this terrible scourge, known practically throughout the world's history as far as campaigns are concerned, no longer became a nightmare to us. We went to our beds and slept well, with that feeling of satisfaction which comes to one, for instance, after having given an anti-diphtheritic injection in a suspicious throat. Fatality became a rarity, except in those unfortunate neglected patients who were practically moribund on admission. Even a good many of these convalesced under treatment.

In these amœbic dysentery cases the fever was slight and the onset gradual, as compared with the bacillary type. The constant tenesmus in most cases was most pitiful to watch; wasting was very rapid and very marked. The stools at first were copious and frothy, passing to small, frequent, bloody, mucus stools. It is in the mucus passed that amœba is looked for pathologically.

Bacillary Type of Dysentery.

This epidemic of amœbic infection carried on then till the end of September. In the early part of October, however, a sudden change became noticeable in these diarrhœic cases. The onset was more sudden, accompanied by violent abdominal pain and tenesmus. After one ordinary motion the next two or three stools passed would practically be pure blood, very similar indeed to a hæmorrhagic typhoid. The temperature rose here to 101°, 102°, or 103° in the initial stages, and the patients looked far worse than those with the amœbic variety. But the most striking feature of all was the absolute failure of emetin to produce any beneficial effect in these cases. Here again pathological aid came to our help and saved the situation. We soon discovered that we were confronted with a new type of dysentery—bacillary dysentery—and the whole plan of treatment had to be altered, substituting a polyvalent serum for emetin. I shudder at our statistics without pathological aid in these cases. In practically all cases the Shiga organism was discovered under the microscope.

These two types of dysentery were the most anxious cases we had to treat, except the meningitis and paratyphoid fever. I would urge upon my hearers then to keep in mind the possibility of mixed infection. In these cases it was my practice till confirmatory pathological knowledge was obtained to administer both forms of treatment. I usually gave one grain of emetin hydrochloride daily and 40 c.cm. antibacillary dysentery serum subcutaneously at once, thereby consoling myself by the fact that I had my patient well protected from either infection.

Enteric Group.

In this group of cases we had an exceptionally interesting experience. In the case of the cases of true enteric fever, the signs, symptoms and treat-

ment were the same as those met with in ordinary private and hospital practice.

With regard to the paratyphoid cases, instead of having the characteristic ladder pattern of temperature chart, the temperature assumed the features of a septic chart, yet the patients presented true enteric signs and symptoms. A feature of note was the absence of a palpable spleen and also of spots in a good many cases. Diarrhoea was not common, and constipation was a common and obstinate symptom. Haemorrhage and perforation were also not common features.

The similarity of the initial symptoms of this complaint to acute influenza was worthy of note. About the early part of November, when the prospect of the evacuation of Gallipoli was contemplated, some of the regiments were sent back to Lemnos to Sarpi Camp to rest. On the night of their arrival they were welcomed by a terrific thunderstorm, accompanied by a heavy downpour of rain. Their tents not being properly trenched, it followed that they became literally washed out of their bunks, and spent most of the night thoroughly saturated. In consequence of this and bodily fatigue from their previous trench life, many of them were admitted to the 3rd Australian General Hospital with symptoms of acute influenza, including high fever, persistent and severe headache (chiefly frontal), anorexia, and intense thirst, and the usual feverish pains in their limbs and muscles. The fever in some cases rose as high as 105°, but all through was of short duration, usually three to five days. Many of these patients were maniacal, and required strapping in bed. To those who have had experience in these cases the diagnosis was apparently not difficult. At the end of three to five days' treatment with the usual antipyretic and dietetic remedies the fever subsided and one looked for progress towards convalescence. In a good many cases, however, this did not happen. The fever abated, but left the patient in a very depressed, low-spirited condition, in which he remained for a few days, and then gradually his temperature began to rise and a typhoidal state ensued. The fever continued its erratic course, and showed little signs of reacting to treatment. The differential Widal test was applied in all these cases, and in almost every one a positive paratyphoid A or B reaction was obtained. These were not cases of men who had been "off colour," so to speak, for a week or so previously, as in cases of ordinary enteric fever, but were cases in which the onset of the paratyphoid condition was sharp, complicated and veiled by symptoms of an attack of acute influenza. We know how frequently influenza symptoms are the precursor of enteric fever; but in these cases the interesting point was the acuteness of onset.

All the patients had been previously inoculated. Deaths were very few indeed. In one case that terminated fatally through pulmonary complications there was an interesting condition of acute paratyphoid septicaemia, with gangrene and abscess of the lung.

The attainment of convalescence in the majority of these cases was fairly rapid. An interesting fea-

ture with regard to the serological diagnosis, especially in reference to the paratyphoid cases, was the fact that no conclusive serological result was obtained till the patient was well on the road to convalescence, with a normal temperature—an important point to bear in mind—even though this test is applied on two or three occasions previously.

Serological Test.—The blood was drawn from the patient's ear or finger and collected in Wright's glass pipettes, both ends being hermetically sealed. It was allowed to stand till the clot contracted and expressed the serum. This serum was taken and diluted with saline solution from 1 in 100 to 1 in 400 and 1 in 800. To this was added in the same dilutions cultures of typhoid, paratyphoid A and B bacilli, respectively, and kept at a certain warm temperature for a period of 24 hours. The degree of precipitation formed in the various dilutions determined the infection the patient was suffering from.

Fallacy.—An inoculated patient is admitted to hospital presenting signs of some very acute infection. In your eagerness you at once wish to eliminate the possibility of enteric. His blood is sent for serological examination. The report returns, showing it to be negative to enteric and the paratyphoid bacilli. The case proceeds, but the patient's temperature chart and general condition do not satisfy you with your initial serological diagnosis. The serological test is again applied, with the result that an equal infection of enteric and one or both of the paratyphoid group is returned. Your belief still being that he is suffering from one of the enterica group of diseases obliged you to have a third or even a fourth serological test performed. After a few days' treatment, before you give up hope of serological aid in your diagnosis, you are rewarded by a definite positive serological result.

Now the fallacy lies in the too early application of the serological test in these inoculated typhoid and paratyphoid patients. You must allow a certain interval of time to lapse between the period of infection (difficult to obtain in a good many cases) and the time suitable for applying the serological test. Usually a period of from 10 to 14 days will suffice, allowing the antibodies sufficient time to produce their reactions. I have already stated that it was well on during the period of convalescence from typhoidal state before a definite serological result was obtained, especially in the paratyphoid group.

Treatment.—The usual expectant and dietetic treatment was carried out, as in ordinary hospital practice. Hyperpyrexias were treated by cold sponging, etc. The excreta were boiled away and the pans passed through boiling water and allowed to lie in carbolic solution till further use. Bed linen, etc., was soaked in carbolic solution and passed through a steam sterilizer before going to the laundry. There was no instance that I can remember in which a case arose, the result of infection from the enteric wards, and cases of relapse were conspicuous by their absence—a great compliment to the nursing and sanitary staffs. The death-rate was exceedingly low, proving the true value of inoculation as a protective agent in these cases.

Jaundice Epidemic.

Herein lies and still exists a great deal of controversy regarding the true specific infective cause of this complaint. Some adhere to the infective aspect, others to the catarrhal. Both aspects, to my mind, are feasible, but to attribute this epidemic to a definite specific organism as the sole cause is still a debatable point. My own leaning is towards the catarrhal side, spreading to the ducts and producing a partial blockage, with subsequent jaundice. In no case in my experience was there complete blockage of the biliary flow (obstructive jaundice). All the predisposing factors towards the production of a catarrhal state were present, *viz.*, exposure to wet and cold, frequent attacks of gastro-enteritis, tinned foodstuffs, etc. It was a noticeable feature in these cases that the majority soon reacted to treatment by rest and careful dieting and eliminatives. Many of the patients preferred to go about their work, the ailment producing very little effect on them. Except for slight weakness and, in some instances, cardiac disturbances, their convalescence was unimpeded. We had cases of pneumonia, enteric fever and dysentery followed by jaundice whilst convalescing in the hospital. Such cases are not uncommon in private practice. I would ask you to pay particular attention to the diarrhoeic aspect, if I may so term it, in relation to this disease. In practically every case that was admitted to hospital for treatment for jaundice alone, the patients gave a history of having previously suffered from gastro-entero-colitis in one form or another, with frequent and bloody stools (or, as they called it, dysentery), and in nearly every case subsequent to recovery, partial or complete, from this complaint, jaundice followed. Numerous other men in the same regiments, who had slight attacks of gastric trouble, suffered from jaundice, but carried on as if nothing was wrong with them. Would you call this an epidemic jaundice, due to a specific organism alone, or would you simply attribute it to a catarrhal condition, subsequent to a gastro-entero-colitic attack, whether due to specific infection, dietetic excesses, or exposure to wet and cold?

An ingenious method of endeavouring to discover a specific organism for this complaint was devised by Major Hurst. It consisted, if I remember rightly, of a hollow olivary-bodied brass instrument, about the size of an acorn, perforated at the sides. Attached to this was rubber tubing of enough length to allow the instrument to be swallowed and pass into the duodenum. The contents of the stomach or duodenum could be sucked up into this instrument by an evacuator placed at the end of the tubing. On a starvation diet this instrument was swallowed with tubing attached and the end of the tube fixed to the cheek by plaster. After an interval of from 8 to 12 hours the contents were evacuated and tested chemically, to ascertain whether gastric or intestinal fluid was being examined, thus proving that the instrument had or had not passed into the intestine. The contents were then subjected to pathological examination. Whether any definite micro-organism was discovered that could be the specific

cause of the so-called epidemic jaundice or not awaits to be seen.¹

The temperature in these cases was never high—about 100°. The liver was palpable and tender; tenderness on pressure was elicited over the gall bladder. The usual pigmentary changes were present, and the physical depression and cardiac inhibition were also in evidence. I have already stated that these cases yielded rapidly to treatment with rest, diet and laxatives. An interesting feature or sequela of this complaint was the marked physical weakness during convalescence and the cardiac irritability. These, in the majority of cases, rapidly improved, but in some the symptoms remained for some time.

Beri-Beri Cases.

These cases began to appear about the latter end of November and throughout December, 1915, and January, 1916. You will recall the fact that this complaint is a form of polyneuritis, occurring endemically in tropical and sub-tropical countries, and characterized by sensory, motor and circulatory disturbances. Bacteriological evidence has as yet failed to throw any light on a specific aetiology, but the results of such workers as Fraser and Stanton are conclusive evidence that, so far, a defective diet is the essential factor. This has been readily noticed in Eastern countries living on a rice diet, the grain freed of its pericarp (polished rice), overcrowding, unhygienic conditions and exposure may be added as predisposing factors.

Symptoms.—The usual symptoms that these patients exhibited were those of polyneuritis, *i.e.*, paresis, especially in the lower limbs, paræsthesia, hyperæsthesia, tenderness along the nerve trunks, loss of deep reflexes, and in some cases muscular atrophy. To these were added disturbances of circulation, palpitation attacks, and attacks of dyspnoea with weakened pulse, and in some cases signs of venous congestion. Many cases presented œdema of the extremities and trunk. One of our own nursing staff was attacked by this disease, and her own anxiety about herself was caused by the fact that she was becoming so stout. Evidently she presented no signs of neuritis at the time, for in a dropsical condition she undertook a long walk and a stiff climb one afternoon, and returned to hospital little the worse for her adventure—a lucky escape from the possibility of a sudden attack of heart failure. To my knowledge we had none of the acute pernicious types, with rapid onset of symptoms and death in a few days from cardiac failure or œdema of the lungs.

Some cases presented no œdema at all (the dry form); but in these cases wasting of the muscles was a marked feature. In other cases the patients complained simply of weakness in the legs, paræsthesia and attacks of palpitation.

Treatment.—The treatment of these cases is of a very prolonged nature, requiring weeks and months at a time. The patients were confined to bed, and a diet rich in nitrogenous (vitamine) food was administered. The bowels were kept open by laxatives.

¹ A. Stokes and J. A. Byle, *Journal of the Royal Army Medical Corps*, September, 1916 (Abstract published in *The Medical Journal of Australia*, February 24, 1917, p. 106).

For the intense pain in the limbs morphine had to be administered and the limbs kept warm, either by bandaging or by hot bottles. In the oedematous cases the oedema was slow in disappearing, but ultimately subsided to general eliminative methods. As the patient made progress towards recovery massage was administered.

Irritable Hearts.

With regard to this great clinical interesting condition I will not encroach upon our time, but would refer you to that excellent paper by my esteemed friend and colleague, Dr. Richard Stawell, of Melbourne, entitled "The Recruit's and Soldier's Heart," which appeared in *The Medical Journal of Australia*, January 20, 1917.

I may be pardoned for stating that this interesting clinical condition caused many an argument between Dr. Stawell, our brother officers and myself, especially in regard to "boarding" these cases as physically unfit for further service. In reading that paper of Dr. Stawell's one cannot but be convinced that it is the essence of a great clinical experience by a calm, deliberate and well-balanced mind.

Cerebro-Spinal Meningitis.

Of the cases in this class of infection, especially those due to the *meningococcus intracellularis meningitidis*, we met with varying success. Here the earlier the case is suspected and the earlier the case is brought under treatment, the better are the results obtained. The customary method of treatment by isolation, lumbar puncture and the injection of serum, combined with sedative and eliminatives, was carried out—a treatment with which you are all familiar.

These then were the chief items of clinical interest which we met with during our sojourn at Lemnos. The fly pest was a terrible curse to us the whole time we were on the island. The Egyptian labourers who preceded us had fouled all our hospital site in their customary unhygienic manner, and this gave the flies a golden opportunity for propagating their species. Diarrhoea, if not actual amoebic dysentery, was present amongst the natives, and there is no doubting the fact that these infected labourers, who defaecated anywhere where it suited them, together with the fly pest, aided greatly in the development and spread of amoebic infection throughout the island.

Egypt.

We arrived here about January 22, 1916, leaving Lemnos in the depths of winter, and with sore hearts, for the tent life and practically outdoor existence were, in many ways, much preferable to our existence in the summer heat of Cairo. We established ourselves at Abbassieh in Military Barracks, which were undergoing reconstruction suitable for hospital work. After a great deal of bargaining and friction with the authorities and a good deal of cleaning up, which seemed to follow us wherever we went, we were rewarded by occupying a very fine and commodious building. With a brief interval in which most of us took the opportunity of visiting

the historical sights in that ancient capital, we were soon in harness again.

Our experience here was of a very mixed nature. We seemed at times to be the "Hub of the Universe," so to speak, and received patients from every part of Egypt, especially along the Canal Zone. Convalescents and chronic cases returning from England and Malta found their way to Abbassieh for boarding purposes. Clerical work increased by leaps and bounds. Muscular rheumatism had no limitations, and what nightmares "V.D.H." and "P.O.U.O." were, only those who have experienced military hospital work could appreciate. We had the consolation that other hospitals were in the same predicament; the work, though uninteresting, was carried out without demur.

The same ailments that we encountered at Lemnos were met with in Egypt, with a few additions of clinical interest, viz., small-pox, relapsing, sand-fly and Malta fevers; in fact, pyrexias galore. Some interesting cases of bilharzia infection were also met with.

In connexion with this latter disease, a very interesting demonstration was given to the profession in the Cairo School of Medicine by Lieutenant-Colonel Leiper, who, with his staff, was sent out from England to investigate the origin of this complaint. The organism, *Miracidium*, its intermediate host, fresh-water molluscs, and its methods of entering the body were very clearly demonstrated.

With regard to the small-pox cases, the interesting features concerning them were the continued high fever—105° to 106°—with very slight remission after the appearance of the rash, accompanied by intense headache and great prostration. The invasion was usually sudden, manifested by chill and vomiting. Lumbar pain, though present in cases under my observation, was trifling in comparison to the intense headache and prostration. The prodromal rash was of a morbillar or scarlatinal character for a few days, followed by a maculo-papular rash on the forehead, wrists and body. Scattered here and there were umbilicated vesicles, which clinched the diagnosis. Most cases were of the discrete form. The death-rate, I regret to say, was very high in these cases.

Vaccination had been performed in all cases within a period of seven to twelve months previously, but with questionable success. On the patients being questioned regarding vaccination the usual reply was that they had been vaccinated on two or three occasions previously, "but it did not take well."

These cases were immediately isolated in a special local hospital for treatment, conducted by a local physician, and the usual precautions against infection of the other patients in the wards by re-vaccination, etc., was carried out.

In conclusion then—

(1) The value of early and repeated inoculation as a protection against typhoid and paratyphoid A and B has been definitely proved throughout our experience in Lemnos and Egypt. That in the majority of cases it did ameliorate the symptoms and

shorten the duration of the illness goes without doubt. The uninoculated cases, though few in number, suffered the most.

(2) It becomes incumbent upon us as a profession to see that vaccination in regard to small-pox is performed successfully. Cases that do not take should be done again till a successful reaction is obtained. The death-rate in the cases that passed through our hands with the history that they were vaccinated "but did not take well," impressed upon one's mind the absolute necessity of performing this operation to one's entire satisfaction.

(3) That there is every possibility and facility for the spread of dysenteric infection to Australia goes without saying. Cases have been previously recorded in Melbourne, and it behoves us in treating acute diarrhoeic cases in returned soldiers to be always on our guard for amebic and bacillary infection. Always be on the look-out for "carriers," without symptoms, and for mixed infection. If in doubt, apply both treatments while awaiting the results of the pathological examination of the stools.

So ends a short story of a great and interesting clinical experience. Never did I dream of being associated with such a body of learned gentlemen of our noble profession, who, throwing up their lucrative practices and petty jealousies, professional or State, worked so ardently and sympathetically for the true patriotic cause for which they left Australia's shore in connexion with the 3rd Australian General Hospital in May, 1915.

Little did our small band dream of the opportunity that lay in store for them of meeting the highest in the professional sense that the Old Country could produce, sent out to the Orient, specialists in their own departments, to endeavour to solve the aetiology and management of the epidemics raging at that time.

Seldom has such a golden opportunity presented itself for the sifting of great minds and great clinical experience on current epidemics, as did occur at those well-attended Anzac Medical Meetings held in Cairo. What a glorious treasure-house to the junior mind! Who could forget? Were our labours in vain? Therapeutical and statistical results will alone tell.

To the sisters, nurses and orderlies in connexion with the 3rd Australian General Hospital Australia owes the deepest gratitude. Their interest in the welfare of their patients and their devotion to duty was beyond all praise. The inconveniences which the nurses underwent during the sojourn at Lemnos were borne without comment. Could our patients at Lemnos ever forget the "Christmas cheer" prepared for them by the nursing and orderly staffs? I ask them. Some of our unit have returned home, others broke loose to other departments, but the main body, I believe, are still at their posts in England. Good luck to them!

In conclusion, I am sure you will agree with me that Australia may be well proud of all her hospitals at the front; and as true sympathizers with them in their arduous tasks, and as true patriots,

we will keep the home fires burning and give the warmest of welcomes to our sisters, nurses, doctors and fighting lads on their safe return to their native land.

SURGERY OF RUPTURED BLADDER.

By C. E. Todd, M.D. (Brux.), M.R.C.S., Eng., L.R.C.P. (Lon.),
Surgeon to the Adelaide Hospital.

In a communication describing a case of ruptured bladder, some time ago, I mentioned that I had injected eight ounces of saline into the bladder and had withdrawn a like amount. It might be thought that I recommended this plan as a means of diagnosis in this class of case. I do not, however, at all. If the injured bladder contains septic urine, the septic fluid is apt to be distributed far and wide in the peritoneum. If the clinical signs and history seem to point to a ruptured bladder, the proper treatment is to explore through a suprapubic opening. The best way to sew up the bladder is by a single layer of interrupted stitches placed very close together. These bring the cut surfaces very accurately together, and it is the raw surfaces that alone unite. Either iodized or chromic gut may be used; if the former, it matters not whether the stitch goes into the mucous lining of the bladder or not; if the latter, it is best to avoid the mucous membrane. It must be borne in mind, however, that the mucous coat of the bladder is apt to slip away from the other coat, especially near the top, and it would be better to include all the bladder coats in your stitch them to leave a raw surface, and this applies whatever suture material is used. Those cases, e.g., rupture, tumour, or stone, have done best of all in which I have sewn up the bladder and not passed any instrument afterwards, but I always feel that this is rather dangerous. It must be remembered that the stay suture holes often leak, and when this occurs, the escaping urine in the tissues rapidly causes a large bladder hole. It is better not to put the stay sutures right through the bladder, or, if you do, they should be close together, so that if you decide to sew the bladder up without drainage you can cut out the parts with the stay suture holes in them.

Reports of Cases.

REPORT OF A CASE OF CÆSAREAN SECTION UNDER RECTAL ANÆSTHESIA.

By Arthur E. Panting, M.B., B.S., B.Sc. (Melb.),
Zeehan, Tasmania.

M.C., a *III-para*, seven months pregnant, complained of swelling of the right foot. There were no other symptoms. The urine, when boiled, became practically solid with albumin. In spite of energetic treatment, the dropsy progressed to general anasarca. On the fourteenth day I made an attempt to pass a bougie into the uterus, but owing to the intense oedema of the vulva and the high position of the cervix, due to postural treatment, or perhaps owing to lack of skill, I failed. The woman's condition grew rapidly worse, and the lungs and heart showed embarrassment; moreover, it was impossible to get any assistance. On the fifteenth

day, as a preliminary measure, I washed out the bowel and gave a hypodermic injection of morphine and atropine. This was followed by a small rectal injection of oil-ether and chloretone, and later by a larger injection of oil-ether. A condition indistinguishable from natural sleep resulted, save that the corneal reflex was abolished. When the abdomen was opened the uterus was found to be intensely congested, pitting on pressure. The peritoneal fluid was under tension, and the veins of the *pampiniform plexus* greatly dilated. Haemorrhage from the opened uterus was very free for a second or two, a fact to the patient's advantage; but good contraction was easily elicited after removal of the contents and dilatation of the cervix from within. The foetus was alive, but intensely dropsical, and no attempt was made to resuscitate it. The uterus and abdomen were closed in the orthodox manner and the patient replaced in bed. On awakening three hours later she felt a little drowsy, but there was neither pain nor vomiting. The following day she felt well and her appetite returned. In two days the urine was free of albumin and in a week the dropsy disappeared. The further progress was without incident, and in three weeks she was sitting out of bed. This is the second occasion on which I have used rectal anaesthesia with good results. When such an operation as Caesarean section has to be undertaken single-handed, the method would appear to possess great advantages.

Reviews.

SOLDIERS' STORIES OF THE WAR

The Returned Soldiers' Association of New South Wales has issued the second edition of a book entitled "Anzac Memorial."¹ There are many reasons why this book should be bought and kept, and not borrowed from a friend. In the first place, it is a good book, and contains information of value, as well as stories worth reading. In the second place it has been produced by a worthy society, consisting of men who have fought for the Empire. And lastly it is a memorial to those who have fallen, a reminder of their sacrifice and their boundless bravery. It is also a memorial of those who live, after having faced death in the battlefield and having contributed to the renown of the magic name of Anzac. There is, therefore, no doubt that everyone should have a copy.

The contents of the book have been arranged with care and some skill. Over 200 pages are devoted to a complete list of the men who have fallen and of those who have been posted as missing. The list appears to be accurate, but the Editor, recognizing the liability of error in the compilation of lists anticipates that some mistakes, omissions or other inaccuracies will be discovered, and begs those who find them to let him know. Then follows the portraits of men who have distinguished themselves. In this part the Editor and the publishers have not done so well. Some of the portraits have been reproduced indifferently, and there is no system of arrangement. We miss the indications of the division of the Army in which the various men are. There is no mention that our members who have earned honours belong to the Australian Army Medical Corps. A very serious defect is the omission of any mention that General Sir Neville Howse has been appointed Director-General of Medical Services of the Australian Imperial Force, or of his having received the honour of knighthood. The third section of the book is made up of enthralling stories of our boys from the front. Many of these stories have been published elsewhere, but the Editor acknowledges the fact of previous publication, and the stories are worth repetition. Interspersed among these stories are verses composed in a spirit of patriotism. An excellent record of the Jutland sea fight forms a fitting *finale* to the collection. As a penultimate chapter we find one that should have been omitted. To introduce the text of the Dardanelles Commission's report, with its unwelcome in-

criminations and plain speaking, seems to us to be quite out of place in a book intended to be a tribute to the fame of our Anzacs. Our Australian boys have done their duty so gloriously that it comes like a jarring note, a discord, to be reminded of the *faux pas* of the Gallipoli campaign. No doubt the defects to which we have called attention will be remedied in the third edition. We repeat, it is a book that everyone should buy.

THE HEALTH OF PORT ADELAIDE.

Dr. P. Bollen has compiled his annual report on the health of the city of Port Adelaide for the year ending September 13, 1916. This report is published as part of the Mayor's report, which was presented to the City Council on November 30, 1916.

Vital Statistics.

The birth and death rates are calculated on an estimated population of 25,877. The number of births registered during the year was 775. This is equivalent to a birth-rate of 29.95 per 1,000 of population. The number of deaths registered in the city was 275, and to this number the Medical Officer of Health adds 46, representing persons usually resident in the city who died in institutions outside. The total was therefore 334, and the death-rate 12.9 per 1,000. There were 63 deaths of infants under one year of age, which is equivalent to an infantile mortality of 81 per 1,000 births. The infantile mortality for South Australia during the year 1915 was 67.3. The birth-rate has varied between 29.95 in the year under review and 37.65 in 1913, in the last six years. In the same period the lowest death-rate recorded was 12.15 in 1914, and the highest 14.12 in 1915. The birth-rate was lowest in the December quarter and highest in the June quarter. The death-rate was lowest in the December quarter and highest in the March quarter, and the infantile death-rate was lowest in the June quarter and highest in the March quarter.

Infective Diseases.

The most extensive epidemic was one of measles. In the first quarter of the year there were 415 cases, and in the whole year there were 736. The deaths from morbilli numbered nine, which is equivalent to a case mortality of 1.2%. In addition, there was one case of measles imported. There were 83 cases of diphtheria, and one imported case. In addition, there appear to have been four cases in the Adelaide Infectious Diseases Block of the Children's Hospital, which brings the total up to 88. Twelve of the patients died. The case mortality of 13.6% is unduly high. There were 241 cases of pertussis, with three deaths, which yields a case mortality of 1.2%. Nine cases of epidemic cerebro-spinal meningitis were reported in the year, and four cases were imported. No record is given of the number of deaths. There were 15 cases of enteric fever, without any deaths, and 30 cases of pulmonary tuberculosis, with 12 deaths. There were no deaths among the 55 scarlet fever patients, and no information is given of the number of fatal cases among the 15 who suffered from erysipelas.

General Hygienic Work.

The work of visiting houses and schools for the purpose of dealing with infectious disease, and of controlling the hygienic conditions appears to be divided between the Sanitary Inspector and the City Nurse. The former disinfected 102 rooms in 81 houses, visited 2,413 premises, inspected 30 building sites and paid 237 visits to buildings during erection. In connexion with the sanitary work the second Inspector made 1,189 inspections and 1,419 re-inspections. In all, 1,093 notices were issued, and 805 of these notices were complied with. The City Nurse visited 1,647 infectious cases, paid 374 visits to schools, and took 272 swabs for examination. Under her direction 107 houses and 135 rooms were disinfected.

A large part of the Portland estate and of Port Adelaide proper was connected with a deep drainage system during the early months of 1916. Street watering with salt water was continued during the summer, despite the protest of the Medical Officer of Health. No progress has been made in connexion with the surface drainage scheme which is under consideration.

¹ Anzac Memorial, second edition, published by the Returned Soldiers' Association of New South Wales: 1917. Sydney: Zetland Factory, William Brooks and Co., Ltd. Pp. 511, illustrated, dummy 8vo. Price: In plain cover, 6s.; in cloth, 10s. 6d.; Edition de Luxe, £2 2s.; Royal Edition, £10 10s.

The Medical Journal of Australia.

SATURDAY, MAY 12, 1917.

Compulsory Enlistment.

The Federal Committee of the British Medical Association in Australia considered at its meeting on March 25 and 26, 1917, a motion referred to it by the New South Wales Branch to the effect that steps be taken to introduce compulsory enrolment of all registered medical practitioners for enlistment in the Australian Army Medical Corps. The New South Wales Branch were influenced in the framing of this motion by the belief that it would be admissible for the Governor-General to give effect to this wish by proclamation under the Defence Act without further legislation. The object was admittedly and openly to bring every member of the profession under the authority of the military, in order that the suitable men might be persuaded to join the Australian Imperial Force. The Federal Committee was informed that a high legal authority had expressed the opinion that the clauses empowering the Governor-General to conscript the community for home service could not be applied to one section. As the motion was but a means to an end, the New South Wales representatives were in accord with their colleagues from other States that it would be waste of time and energy to ask for legislation for the compulsory enrolment of members for service within the Commonwealth. Since it would be necessary to ask for a special Act of Parliament, they all favoured a bold attempt to secure compulsory enlistment for service abroad or at home. But it was felt that before so serious a step could be taken, the members of the profession should be consulted individually. The desire of the Federal Committee was to be armed with a mandate from the doctors of Australia which they could take to the Governor-General. It could be shown that the medical profession stands in a wholly different position to the great struggle than do the general com-

munity. Medical men have a duty to perform to the public. They acquire skill and knowledge for the purpose of preventing disease, maintaining the health of the community and dealing with disease or injury when it arises. A large section of the public has taken up arms in the service of the Empire and the members of the medical profession have a duty to perform for these brave, unselfish patriots. The task of providing an adequate medical service for the military forces as well as for the civil community has become increasingly difficult. But while it is admittedly difficult, it is by no means impossible. Certain doctors are of great value for certain functions in the military machine. Others are less suited for this purpose, but can give satisfactory medical attendance to the civil population. Under the voluntary system there is wastage of effort, and the determining factor which has directed men to the front has been keenness to serve and willingness to make a considerable sacrifice. We have pleaded over and over again for every medical man to place himself unreservedly in the hands of the military authority, in order that the determining factor in the choice of those who would be sent to France or to Australian hospitals in England and elsewhere would be suitability to serve. The Director-General has asked us repeatedly to appeal for more men to join the Australian Imperial Force. To-day he admits that he has been asked to send forward as many suitable men as possible without delay. It is therefore obvious that the voluntary system cannot be relied upon to meet the requirements both of the military situation and of the civil community. The cause of the failure of the voluntary system is not far to seek. Many men have held back because they believed that the man next door would hold back. Every one will now have an opportunity of recording his vote, and we anticipate that there will be an overwhelming majority for the equalizing of the national duty. It may be that some will be inclined to oppose the scheme on the ground that no Minister would be likely to grant conscription for a section of the community. We would venture to point out that this is quite outside the question. If the medical profession registers its desire to accept its duty to the soldiers fighting as well as to the

people at home, the onus of refusing such an offer must rest with the Federal authorities. Should the offer be refused, other means can be taken to achieve a similar end, but the alternative would be cumbersome, slow, uncertain and costly. The argument set out should convince everyone that the medical profession stands in a peculiar position, and should have peculiar treatment.

The suggestion that the doctors were to discuss this matter led to an outburst of frenzy on the part of the Labour Party. In a recent issue of the *Worker* of New South Wales attempts are made to stir up public opinion against the action of the British Medical Association in "bringing in conscription behind the backs of the people." Incidentally we learn that the Political Labour League is the voice of the public. Our contemporary has an apt way of distorting the facts of the situation. The medical profession in the Commonwealth was almost to a man in favour of conscription when the matter was referred to the people. The reply of the majority was opposed to conscription, and those who had high ideals have smarted under the sting ever since. What more logical position could medical practitioners take than to ask to have a little conscription all to itself; especially since its labour is a labour of love and an endeavour to lessen the number of deaths and the amount of suffering of brave Australians? Moreover, we would urge those who are inclined to take a short-sighted view of the situation that it is only possible to safeguard the needs of the civil population during the continuation of the war if a judicious selection be made of those who should and those who should not go to the war, and this can only be achieved by an organization of the whole profession, and the introduction of discipline in a body that does not as a rule obey any master.

JAUNDICE OF INFECTIVE ORIGIN.

In the present issue we publish an article full of information and suggestiveness by Dr. Herbert J. Stewart. This paper was read at a meeting of the Queensland Branch of the British Medical Association on April 13, 1917. The members present realized that the material comprising the article was so important and so varied that it would be practically impossible to discuss it until an opportunity

had been given to them to read it over carefully. The discussion will therefore follow at an early date. In the course of his remarks, Dr. Stewart expressed the view that the cause of the icteric conditions met with among the troops in Egypt and at Lemnos was more probably a catarrh of the biliary passages than an infection, although he admits that the subject is *sub judice*. This subject has received much attention from pathologists during the past two years, and at the present time there is a mass of evidence concerning the pathology and aetiology of some of the cases of so-called infective jaundice. In the first place Inada, Ido, Hoki and Heniko have demonstrated that a spirochæte, the *Spirochaeta icterohaemorrhagica*, produces one form of infective jaundice. This form has been investigated by Stokes, Ryle, Beitzke, Herxheimer, Fullerton, and more recently by Bertrand Dawson and William E. Hume.¹ The clinical characters, the pathology and the aetiology have now been established. The onset in these cases may be gradual or sudden; the early symptoms consist of fever, vomiting, prostration and pains. Jaundice is observed between the second and the seventh day of illness. Haemorrhages, enlarged liver and spleen and herpes are all frequent symptoms. It is held that jaundice is a very common, but not a necessary manifestation of spirochætal disease. It is produced by a congestion involving the duodenum and by an increased viscosity of the bile. It is quite possible that a deeply toxæmic condition, terminating in death, may be set up independently of the jaundice. Bertrand Dawson and Hume suggest that the toxæmia in some cases can be attributed to a secondary bacterial infection. A second form of jaundice is also seen, namely, that occurring in the course of an attack of enteric fever or of paratyphus fever. It has long been recognized that jaundice may complicate other infections, such as influenza, but its occurrence is rare. In the enteric form of jaundice, it is held that an obstruction takes place somewhere in the biliary tree. From a study of the pathological condition recognized after death, it would appear that the seat of blocking is the duodenum, which is in a state of acute inflammation. At times pylephlebitis has been observed. There is then a third class, which is frequently spoken of as catarrhal. But here again it has been shown that a careful search enables the bacteriologist to demonstrate the infective nature of the icterus. It has been suggested that the jaundice met with in influenza and pneumonia is similar to that met with in these so-called catarrhal cases. Any septicæmia may give rise to atypical local manifestations, and it is not surprising that occasionally the duodenum and the ampulla of Vater may be involved in a congestion or inflammation in the course of a specific infection. The clinical characters and the morbid anatomy of all forms of epidemic jaundice point to an infective process, which may be varied. While two forms are well defined, namely, spirochætal disease and enteric

¹ Jaundice of Infective Origin, by Bertrand Dawson and William E. Hume, *The Quarterly Journal of Medicine*, October, 1916, and January, 1917.

jaundice, the other forms present many variations. It is inadvisable to classify them as catarrhal, since an infection has been traced in the vast majority of cases investigated.

THE PSYCHOPATHIC LABORATORY.

Students of psychology have gradually forced upon an unwilling laity the doctrine that criminality is more often born of an unsound or unstable mind than of viciousness. A careful analysis of the mental and physical characteristics of delinquents and recidivist criminals has revealed the fact that abnormal mentality is frequently present. Experience has taught that a youthful offender may be brought within the scope of the law as a result of the "superimposition" of faulty environment on mental deficiency. Judges and magistrates have been compelled to recognize that imprisonment or detention in reformatories has no deterrent effect on these delinquents, and that the more oppressive the punishment meted out, the more hopeless becomes the outlook for ultimate reclamation. The majority of these abnormal delinquents and future criminals come into conflict with the law at an early age, and the psychiatric expert has evidence that long before the first offence was committed, there were signs of mental deterioration. Modern psychiatry has taught that the diseases of the mind must be dealt with like the diseases of the body; that mere restraint and protection of the rest of the community is out of date and inhuman. From the old asylum scheme, evolved the institution for the active treatment of the insane; and as the next logical step came the psychiatric clinic. The idea of attempting to arrive at an early diagnosis, in order that therapeutic measures might be applied while there was still hope of arrest of the disease or its cure was but a chapter borrowed from medicine. But it must be recognized that there are more persons with mental abnormalities outside the mad-house than within it. The types of mental disorder vary from a simple weak-mindedness to advanced mental disorder or dementia. The problem acquires a social aspect, when it is realized that criminality and the criminal tendency is often a sign of mental defect. The sociologist insisted long since on the establishment of schools for mentally deficient children, and it does not redound to the credit of any State that does not make adequate provision for this class of unfortunate citizen. America has seized the right conception concerning the relationship between the delinquent and the mentally defective individual. Both in New York and in Chicago there have been set up in connexion with the courts of law psychopathic laboratories, where an expert alienist and neurologist is engaged for the purpose of advising the Court in regard to the mental quality of persons charged with various offences. The Eighth and Ninth Annual Reports of the Municipal Court of Chicago contains an excellent account of the work conducted in the largest laboratory for the detection of mental defects in members of the community yet established. The

object of the laboratory is to prevent the infliction of punishment to individuals whose misdemeanours or crimes are the result of an unbalanced mind, and to substitute for a useless and harmful punishment, the proper treatment fitted with scientific nicety to the individual. The experience of this laboratory since its establishment has been that, while pure feeble-mindedness rarely carries in its train a criminal instinct, dementia præcox associated with feeble-mindedness forms the most dangerous defect in this respect to the individual. From the report we learn that great importance is attached to the accurate diagnosis in each case. Manifold mental tests must be applied to detect latent defects, while physical defects must be sought for and recognized with promptness and certainty. The training of the Director of such a laboratory must therefore be thorough, as on his efficiency will depend the success of the scheme. The rights of the unfortunate individual, who is led to commit an offence by reason of his mental disease, have to be safeguarded, and at the same time the safety of the public must not be forgotten. It is not sufficient that laws should be framed to allow a person charged with crime, who pleads insanity, to be examined by a psychiatrist. This merely enabled a man to escape the gallows and arrive inside the asylum. Modern knowledge claims that whenever there is the slightest question as to the actual responsibility of an offender, no matter how trivial the offence may be, the mentality of the individual shall be investigated by an independent expert, who can discover a latent defect, or recognize feigned mental deficiency, and advise the Court how to deal with the individual. There is no doubt that the psychopathic laboratory is the best means of achieving this end.

WAR PENSIONS.

The Commissioner of Pensions of the Commonwealth of Australia has recently issued a statement dealing with war pensions claimed, granted and rejected during the year ending June 30, 1916. In the second year of the war 14,995 claims for pensions in respect of Australians serving with the Expeditionary Forces were received by the Department. Of these, 1,732 were rejected as invalid, and 4,209 awaited determination on June 30, 1916. The total number of pensions granted, after allowances were made for transfers from other States and from overseas and for deaths, numbered 8,754. There were paid to dependents of soldiers who lost their lives while on active service 4,314 pensions, including 1,485 to children under the age of 16 years, 909 to widows, 1,794 to parents and 151 to brothers and sisters. The number of pensions granted to incapacitated members of the Forces was 3,025. The average amount of pensions paid each fortnight to dependents of deceased or incapacitated members of the Forces was £1 4s. 6.34d., while the average amount paid to incapacitated members themselves was £2 7s. 3.95d. The total expenditure on war pensions during the second year of the war amounted to £137,919 16s. 3d., while the cost of administration

was £10,187, or 6.87% of the total. The liability of the Department on June 30, 1916, stood at £368,800 for 26 fortnights. The number of pensions paid to dependants of deceased members of the Expeditionary Forces naturally does not tally with the number of deaths of men on active service. The numbers given, however, are large enough to teach many very serious lessons. The matter of the payment of war pensions is one that is distinct from sentiment. It reveals the financial obligation of the community, and between the lines it is necessary to read how that obligation can be reduced to a minimum. The better the Australian Imperial Force is equipped with medical officers, the smaller will be the total of serious or permanent disabilities of its members. With a full complement of medical officers and a good organization of the various medical departments and services, the amount of disablement and, consequently, the financial burden of the community can be reduced materially.

A CONFERENCE ON INFANT WELFARE.

It was decided last January, by a meeting of the Infant Welfare and Kindred Associations of New South Wales, that a conference should be held in Sydney, in the month of May, to deal with the various problems connected with the care of infants and children. At this meeting an executive committee was appointed. The members are:—Dr. Mary Booth, in the Chair; Dr. Guy Griffiths, representing the District Nursing Association; Mr. A. W. Green, President of the State Children's Department; Miss Alice Friend, representing the Baby Clinics Board; Miss Goldsmith, Honorary Treasurer of the Sydney Day Nursery Association; and Mrs. G. B. Robertson, representing the Health Society and the Kindergarten Union. The Patrons of the conference are Sir Charles Mackellar, Sir Phillip Sydney Jones, Mrs. Andrew Garran, and Miss Rose Scott. It has been planned that there shall be three sections, viz., (i.) a medical section; (ii.) a philanthropic section; and (iii.) an administrative section. Her Excellency Lady Helen Munro Ferguson will preside at the opening session, to be held on May 23, 1917, at 3 p.m., at the King's Hall, Hunter-street, Sydney.

The following have promised to contribute papers at the conference:—Sir Charles Mackellar, Professor D. A. Welsh, Mr. C. H. Knibbs, Mr. A. W. Green, Dr. Mary Booth, Miss Isla Blomfield, and Dr. F. N. G. Stephens. It is anticipated that the discussions will advance reforms necessary to safeguard infant and child life, and that by the interchange of opinions and the recital of experience, progress will be made in connexion with several problems which await solution. The medical profession, as a whole, has been inclined to treat the great social problems concerning the young with something akin to apathy in the past. At the present time there is ample scope in New South Wales for pressing reforms in many directions, not only in regard to infants and children under school age, but also in regard to the health of school children. The Sydney conference should give the members of the medical profession and others who have had an opportunity of studying the many subjects included in the term infant and child welfare, an impetus to assist in directing public and private energies into the right channels.

Naval and Military.

The 291st 292nd, and 293rd list of casualties, issued on May 3, May 4, and May 7, contain the names of 2,818 officers, nurses, and men. The number of killed, or died from wounds or other causes, was 569, including 18 officers, and of wounded 1,863, including 93 officers. The number of missing was 57, including 10 officers. Only one medical

man is mentioned in these three lists. Captain G. B. Lowe is mentioned as having been wounded, but remaining on duty.

The following announcements are made in the *Commonwealth of Australia Gazette*, No. 65, of April 30, 1917:—

Army Medical Corps.

Administrative Headquarters, Australian Imperial Force. Captain (temporary Major) R. E. Shuter to retain temporary rank of Major whilst employed as Consulting Aural Surgeon, attached Medical Section, Administrative Headquarters, Australian Imperial Force. Dated 1st December, 1916.

1st Australian Division.

Major J. J. Nicholas, from 3rd Field Ambulance, to be Deputy Assistant Director Medical Services. Dated 5th December, 1916.

The appointment of Captain O. R. Horwood, in the Australian Imperial Force, has been terminated. Dated 20th November, 1916.

5th Australian Division.

The temporary appointment of Lieutenant-Colonel (temporary Colonel) W. W. Hearne, to be Assistant Director Medical Services, is confirmed. Dated 1st December, 1916.

1st Field Ambulance.

To be Major—

Captain L. Cowlishaw, from Army Medical Corps Training Depot. Dated 1st December, 1916.

2nd Light Horse Field Ambulance.

To be Major—

Captain C. V. Single, from 12th Light Horse Regiment. Dated 1st December, 1916.

2nd Field Ambulance.

To be Lieutenant-Colonel—

Major A. H. Marks, from appointment of Deputy Assistant Director Medical Services, 4th Australian Division, and to command. Dated 1st December, 1916.

14th Field Ambulance.

To be Major—

Captain J. B. F. McKenzie, from No. 3 Australian General Hospital (No. 1 Australian Stationary Hospital). Dated 1st December, 1916.

15th Field Ambulance.

To be Major—

Captain D. C. Pigdon, from Regimental Medical Officer, 22nd Field Artillery Brigade. Dated 1st December, 1916.

The following announcements are made in the *Commonwealth of Australia Gazette*, No. 66, of May 3, 1917:—

To be Surgeon-General—

Colonel (temporary Surgeon-General) N. R. Howse, V.C., C.D., Director of Medical Services, Australian Imperial Force. Dated 1st January, 1917.

Appointments, etc.

His Excellency the Governor-General, acting with the advice of the Federal Executive Council, has been pleased to approve of the following changes, etc., in connexion with the Australian Military Forces, viz.:—

Australian Army Medical Corps.

Captain (temporary Major) C. C. Thompson, from appointment as Officer Commanding No. 12 Australian General Hospital and Staff Officer for Invalids (temporarily), to be Officer Commanding No. 12 Australian General Hospital (temporarily), part time, with salary at rate of £275 per annum, inclusive of all allowances except travelling, whilst holding such appointment. Dated 19th March, 1917.

Lieutenant W. S. Poole, Unattached List, to be Secretary No. 7 Australian General Hospital (temporarily), with pay at £250 per annum, inclusive of all allowances except travelling, whilst holding such appointment. Dated 1st April, 1917.

We have been asked to publish the following notice from the Department of Defence:—

Permission has been given by the Minister to allow civilian medical men to obtain special experience in connexion with the treatment of venereal disease by

attendance at Departmental Venereal Hospitals and Camps. Arrangements have been made that any medical man who desires to go there for a short course, may do so at a time to be arranged with the District Authorities under the following conditions:—

Medical men will have to comply with all rules regarding the camps. They will receive no payment whatever, will not have to wear uniform, will be treated as members of the Officers' Mess, but will pay their own mess account, which is estimated will not be more than 30s. per week. Tentage, bed and bedding will be provided free.

It is advisable for those medical men who have high power microscopes to take them with them.

Any medical man desiring to avail himself of the opportunity to attend a course, should apply in writing to the Principal Medical Officer of the District, who will make suitable arrangements.

Should any medical man desire to attend a Venereal Diseases Camp in a district other than that in which he resides, arrangements can be made between Commandants of the Districts concerned, but no expenses will be borne by this Department.

Public Health.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending April 28, 1917:—

| Disease. | Metropolitan District. | | Hunter River District. | | Rest of State. | | Total. | |
|--------------------|------------------------|-------|------------------------|-------|----------------|-------|--------|-------|
| | Cs. | Dths. | Cs. | Dths. | Cs. | Dths. | Cs. | Dths. |
| Enteric Fever .. | 3 | 0 | 3 | 0 | 19 | 1 | 25 | 1 |
| Scarlatina .. | 29 | 0 | 5 | 0 | 42 | 1 | 76 | 1 |
| Diphtheria .. | 79 | 1 | 9 | 0 | 108 | 4 | 196 | 5 |
| C'bro-Sp'l Menin. | 1 | 0 | 0 | 0 | 5 | 1 | 6 | 1 |
| *Pul. Tuberculosis | 16 | 11 | 0 | 0 | 1 | 0 | 17 | 11 |

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Board of Public Health, Victoria, during the week ending April 29, 1917:—

| Disease. | Metropolitan District. | | Rest of State. | | Total. | |
|-------------------------|------------------------|-------|----------------|-------|--------|-------|
| | Cs. | Dths. | Cs. | Dths. | Cs. | Dths. |
| Diphtheria .. | 54 | 1 | 61 | 3 | 115 | 4 |
| Scarlatina .. | 19 | 0 | 26 | 0 | 45 | 0 |
| Enteric Fever .. | 4 | 0 | 14 | 0 | 18 | 0 |
| Pulmonary Tuberculosis | 25 | 10 | 11 | 4 | 36 | 14 |
| C'bro-Spinal Meningitis | 1 | — | 0 | — | 1 | — |
| Poliomyelitis .. | 1 | — | 0 | — | 1 | — |

THE HEALTH OF QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending April 28, 1917:—

| Disease. | No. of Cases. |
|------------------------------|---------------|
| Cerebro-Spinal Meningitis .. | 6 |
| Scarlatina .. | 13 |
| Diphtheria .. | 37 |
| Enteric Fever .. | 9 |
| Pulmonary Tuberculosis .. | 9 |
| Poliomyelitis .. | 5 |
| Erysipelas .. | 1 |
| Malaria .. | 32 |
| Ankylostomiasis .. | 5 |

THE HEALTH OF TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the week ending April 28, 1917:—

| Disease. | Hobart Cases. | Launceston Cases. | Country Cases. | Whole State Cases. |
|------------------|---------------|-------------------|----------------|--------------------|
| Diphtheria .. | 3 | 5 | 10 | 18 |
| Enteric Fever .. | 1 | 0 | 2 | 3 |
| Scarlatina .. | 0 | 0 | 1 | 1 |

THE BLIND AND THE DEAF AND DUMB.

The annual report of the South Australian Institution for the Blind and Deaf and Dumb, covering the twelve months ending September 30, 1916, has been published in pamphlet form, together with various information concerning the objects and work of the Institution. At the close of the year there were 74 pupils in the school. During the course of the year seven new pupils were admitted, while 17 old pupils left. Three were appointed pupil-teachers in the Blind School, four boys were apprenticed to trades, five girls entered situations, one boy was transferred to the Angas Home and four children returned to their parents. The number of blind persons employed at the Institution was six and of deaf persons ten. The health of the inmates has been good. Two suffered from scarlatina and two from varicella. Otherwise no illness has been met with.

The Committee express regret that the services of two valued teachers have been withdrawn. Miss P. Milne left to be married, and Mr. S. Cooper left to take up the position of Superintendent of the South Australian Adult Deaf and Dumb Mission. Since suitable persons could not be found to fill the vacant positions, three blind pupils were appointed pupil-teachers to fill the gap. The blind pupils are said to be making good progress in music, while elementary carpentry, bootmaking and gardening for the boys, and cookery, laundrywork, dressmaking and housework for the girls are taught with encouraging results. Each pupil has his or her own garden plot, which they work without supervision. They compete eagerly for the prizes given by Mr. A. M. Simpson. The children also showed proficiency in gymnastics and games.

Eight of the employees were serving with the Australian Imperial Force. As far as was known, none had been killed. A Deaf and Dumb Branch of the Red Cross Society was doing excellent work, and contributing usefully to the parent society.

The Committee refer with satisfaction to the fact that the education of the blind and of the deaf and dumb has been made compulsory by Act of Parliament. For 42 years the managers of the Institution have been attempting to carry out the education of every blind and deaf and dumb child in the State. These endeavours have been frustrated to some extent by the objection of some parents to sending their afflicted children to the Institution. It is hoped that the Government will enforce the provisions of the Act and compel all these children to enter the Institution or obtain private tuition. In conclusion, the Committee refer in terms of the highest praise to the magnificent work of the Superintendent, Mr. Samuel Johnson, M.A., and his wife, the Matron.

The income of the Institution during the year aggregated £5,538, and in order to meet their financial obligations the Committee were compelled to borrow over £5,000 from the Endowment Fund, and close on £1,300 from the bank. The sum of £3,206 was contributed by the charitable public, while the Government gave the sum of £1,200 as subsidy. On the other side of the account there appears a heavy item of £6,287, being the deficit balance. Economy appears to have been exercised, but we assume that the maintenance bill must continue to increase during the next year or two. From the figures in the financial statement it appears that close on £6,000 is needed each year. We hope that the Government will see its way to make good part of this sum, and that the charitable public will be able to supply the remainder. An increase of £500 or £600 on the subsidy would relieve the managers of this most excellent institution of a grave responsibility.

We are pleased to note the name of Dr. Frank Wall in the list of those appointed to the Legislative Council of New South Wales,

Abstracts from Current Medical Literature.

THERAPEUTICS.

(138) Alcresta Ipecac in Amoebic Dysentery.

J. W. W. Stephens and D. L. MacKinnon have given up the use of emetine hydrochloride in the treatment of dysentery due to *Entamoeba histolytica* in favour of the employment of alcresta ipecac (*Annals Trop. Med. and Parasitology*, February, 1917). Alcresta ipecac is the trade name for a compound produced by the absorption of the alkaloids of ipecacuanha by hydrated aluminium silicate (Fuller's earth). It is administered as tablets containing 0.15 gm. emetine. This preparation passes through the stomach unchanged, and liberates the alkaloid in the intestinal canal. Patients do not suffer from the nausea and vomiting observed after the administration of emetine in other forms. The authors give a report of their results in 76 cases admitted to the Auxiliary Military Hospital attached to the Tropical School of Medicine, Liverpool. They have made an exhaustive study in chronic cases due to *E. histolytica* as all their patients belonged to the group of chronic "carriers." Daily microscopical examinations of the faeces of the patient have been made over as long a period after treatment as was practicable. Of the patients, 13 left hospital as soon as the treatment ended. They had all ceased to pass cysts a few days after treatment was commenced. Thirty-eight had not relapsed under observation subsequent to treatment. Fourteen cases had relapsed, but four of these had subsequently become free from cysts after a second or a third course of treatment. Four patients were completely unaffected by the use of alcresta ipecac. The remaining cases had not yet finished the first course of medication. After a number of trials, a standard course of fourteen days' treatment, with ten tablets daily, five in the morning and five in the evening, has been adopted. The patient therefore receives $1\frac{1}{2}$ gm. emetine daily. As soon as a patient relapses a second similar course is instituted, and, if need be, a third. The authors consider that their results compare favourably with those obtained by the use of hypodermic injections of emetine or by the employment of Dale's bismuth emetine iodide.

(139) The Fate of Iodine.

T. Sollmann (*Journ. Pharm. and Exper. Therapeutics*, February, 1917) has endeavoured to discover whether the administration of free iodine gives rise to the appearance of iodides and iodates in the blood, or in the tissues. He has also made some experiments to determine whether iodine can be liber-

ated from iodides or iodates existing free or in combination, with the reaction (hydrogen ion concentration) that is known to exist in the body. It is not possible to apply tests for iodine to materials containing protein, or to urine, since any iodine liberated by the reagent is immediately bound by aromatic radicles present in these fluids. By the use of dialysis through parchment or collodion these disturbing factors are removed. It has been found that neither iodides nor iodates undergo any change in blood serum. Free iodine is promptly converted into iodide, but no iodate is formed. When considerable doses of free iodine are administered by the stomach to dogs, iodides alone appear in the blood. No iodine is produced by the addition of acid to the blood or its serum. No iodine is liberated from iodide iodate, from iodide nitrite or from iodide sulpho-cyanide mixtures until the acidity is much higher than that existing anywhere in the body, except in the gastric juice. The alkalinity of the tissues is not sufficient to bind any appreciable amount of free iodine, even in the absence of protein and aromatic radicles.

(140) Treatment of Strychnine Poisoning by Magnesium.

E. C. Cutler and B. H. Alton report the history of a case of poisoning by strychnine in which the patient was treated successfully by the intraspinal lumbar injection of a solution of magnesium sulphate (*Journ. Exper. Medicine*, January, 1917). A female child, aged 1 year and 2 weeks, swallowed 12 or 14 pills, each containing $\frac{1}{100}$ grain of strychnine. After an hour a slight general convulsion occurred. The child vomited once shortly after the first convulsion. The convulsive seizures were repeated in rapid sequence. On admission to hospital the convulsions were almost continuous. The child was cyanotic, and periods of respiratory inhibition were noticed. Ether was given at once. A stomach tube was passed, and the stomach washed out. Attempts were made to give sodium bromide by the mouth and rectum, but the drug was rejected. As convulsions set in whenever the anaesthesia was diminished, 0.9 c.cm. of a 25% solution of magnesium sulphate was given through the fourth lumbar space into the subdural cavity. The head was kept well elevated. The anaesthetic was removed, and the child recovered at once. The convulsions ceased and did not recur. Recovery was uneventful. Experiments have been made upon young cats to determine whether the use of magnesium sulphate by intraspinal injection could protect the animals against lethal doses of strychnine. The experiments showed that the injection of magnesium on the occurrence of the first convulsion could protect against a lethal dose of strychnine. When the magnesium sulphate was given at the same time as the dose of strychnine to the cats, the onset of convulsions was not prevented,

(141) Salicylates in Blood and Joints.

R. W. Scott, T. W. Thoburn and P. J. Hanzlik have estimated the amount of salicylate radicle in blood and in the fluid of joints of persons suffering from rheumatic fever (*Journ. Pharmacology and Exper. Therapeutics*, January, 1917). A method of estimation was employed by which it was possible to measure, with some approach to accuracy, small quantities of salicylates, such as 2 mg. to 5 mg., in 20 c.cm. blood. Measurements were made in five patients, who had received from 4 gm. to 14 gm. of salicylate of soda. The results demonstrated that the concentration of salicylate radicle in the blood was slightly higher than the concentration in the fluid of the joint. The average concentration of salicylate radicle in the blood was 0.02%, while, in the fluid from the joint, it was 0.018%. Some experiments were made on the concentration of salicylate radicle in the blood of rheumatic and non-rheumatic persons. The results indicated that the concentration in the blood of rheumatic patients is lower than the concentration in the blood of healthy persons after the administration of equal doses. The average concentration of salicylate radicle in the blood of healthy persons after a dose of salicylate of soda of 13 gm. was 0.026%, while, in the rheumatic patients after the same dose, the concentration of salicylate in the blood was 0.020%. An attempt was made to demonstrate the presence of free salicylic acid in the fluid from the joints of many rheumatic persons. No free salicylic acid could be found. A series of determinations of the alkalinity of the blood was made in a number of persons, rheumatic and otherwise. These showed that there was no lessening in the alkalinity of the blood in rheumatic fever. The administration of salicylate of soda had no influence upon the alkalinity of the blood.

UROLOGY.

(142) Seminal Vesiculitis.

J. T. Geraghty (*Journ. Amer. Med. Assoc.*, March 10, 1917) states that while the seminal vesicles may become involved in the course of a gonorrhoeal urethritis, a primary non-gonorrhoeal vesiculitis may lead to a stubborn infection of the posterior part of the urethra and of the bladder. In some cases of the latter condition, there are occasional exacerbations in which a visible amount of pus is present in the urine, and periods of urinary irritability occur. In other cases there is evidence of well-developed cystitis, with a history of repeated previous attacks. The diagnosis is not always easy. When epididymitis occurs, and especially if it recurs, the diagnosis of active vesiculitis is evident. As a rule it depends on the results of palpation, and is consequently not reliable. The persistence of a bacteriuria for which no ascer-

tainable focus of infection can be determined, may be regarded as suspicious of a primary vesiculitis. These infections do not respond readily to local treatment, and stripping of the seminal vesicles has proved disappointing in the author's experience. He advocates vesiculotomy, if local measures fail. The vesicles should be thoroughly opened, and the vas as well as the body of the vesicles should be efficiently drained.

A. C. Stokes (*ibid.*) records his experience in 52 cases of seminal vesiculitis. He distinguishes general symptoms, including fever, pain, malaise, and constipation, genital symptoms, and urinary symptoms. After reviewing his data, and recording the alleged bacterial cause in the several cases, he gives some brief accounts of cases. In dealing with the treatment he states that seminal vesiculotomy is rarely indicated, and should not be undertaken unless there is an empysemic vesicle with signs of sepsis and tissue destruction. In chronic cases drainage cannot remove the pathological changes, and recurrence of symptoms occurs after the wound is healed. He advocates the removal of the whole of the superprostatic vesicle in obstinate chronic cases, and claims that this procedure does not materially increase the risk attending the operation of vasotomy. He holds that seminal vesiculitis, as a simple clinical entity, is exceedingly rare. The diagnosis is difficult, chiefly because very little attention has been paid to the condition. The results of treatment of the vesicles alone are imperfect, and it becomes necessary to treat the other tissues adjoining the urethra at the same time. These include the prostate, the trigone, the *veru montanum* and the utricle, which are usually implicated in the infecting process.

R. H. Herbst (*ibid.*) deals with infections of the seminal vesicles as a cause of persistent urethral discharge. He states that in 75 per cent. of cases in which the gonococcus invades the male urethra, it travels back into the posterior portion of the urethra, and in the majority of cases to the ejaculatory ducts and seminal vesicles which become involved. He holds the opinion that it is not sufficient to confine the treatment of gonorrhoea to urethral medication. Spontaneous cure of seminal vesiculitis is exceedingly rare, and stripping rarely leads to a satisfactory result. He discusses the necessity and indications of operative interference. He is inclined to the belief that many cases in which the urethral discharge persists in spite of urethral medication, are cases with vesiculitis. Frequent and painful blood-stained emissions are often associated with enlargement and tenderness of the seminal vesicles. In cases of this kind, he performs a bilateral vasotomy and injects both vesicles with collargol. The urethral discharge disappeared within 48 hours of the operation. He considers it essential in all cases of persistent urethral discharge to examine the vesicles per

rectum. In acute inflammatory conditions the vesicles will be found to be enlarged, soft and tender; they are usually hard in chronic cases. Brief cessation of the urethral discharge also points to the existence of vesiculitis. He details the histories of five cases. In each one there was long-standing urethral discharge, and objective involvement of the seminal vesicles. Urethral medication failed in all. He also refers to other cases in which the discharge persisted after the operation. He attributes this to an implication of the urethral glands or of the prostatic follicles.

(143) Stricture of the Urethra.

F. R. Wright (*Urolog. and Cutan. Review*, March, 1917) deals with certain points in connexion with the treatment of strictures of the membranous portion of the urethra. He finds that 54 % of all strictures are due to gonorrhoea, and are situated in this portion. In addition 10 % are traumatic in origin, and all traumatic strictures are found in the membranous portion of the urethra. Inflammatory strictures develop slowly. During the chronic stages of a gonorrhoea a round-cell infiltration forms, and the urethral wall gradually becomes thickened, and loses its elasticity, and the canal becomes narrowed. He regards the mass of inflammatory tissue as "callus." This mass undergoes organization, and is eventually converted in fibrous, connective tissue. The fibrous tissue contracts, and this leads to a permanent loss of elasticity in the walls of the urethra. In the case of traumatic strictures, there is loss of the tissue of the urethral wall, and the space is filled with blood. As the blood is absorbed, its place is taken by an exudate which becomes organized into fibrous tissue, which obliterates the canal by contracting. There is no thickening of the tissues. In dealing with any stricture, the accepted method of treatment is by dilatation. When only a filliform bougie can be passed, it is necessary to leave it *in situ* for 24 or 48 hours. In order to determine whether the tip of the bougie after passing through the stricture lies within the lumen of the urethra, the instrument should be rotated. If the patient has the sensation of micturition, it may be concluded that the instrument is in the canal. At the end of 24 or 48 hours a second bougie is passed alongside of the first. Later a third and a fourth are passed, until a No. 10 or No. 12 bougie can be passed. Heat should be applied in all cases of inflammatory stricture to ease the passage of small instruments. The subsequent treatment consists in the passage of bougies, which are not retained. In the case of traumatic strictures, there will be no absorption of tissue and no real stretching of the fibrous tissue. In these cases an external urethrotomy must be performed.

(144) Prostatic Calculi.

W. M. Brickner (*Urol. and Cutan. Review*, February, 1917) points out that

prostatic calculi are either calculi in the prostatic urethra or calculi in the gland itself. He does not consider the stones which have been formed higher in the urinary tract and retained in the prostatic urethra as true prostatic stones. He is inclined to the opinion that in those rare cases in which the stone is found in a pouch or pocket, it has probably not been formed *de novo* in the pouch, but has merely lodged in it. At times the stone forms in the gland and protrudes into a pocket. In regard to the real prostatic calculi, he states that small multiple stones are more common than large single ones. Not infrequently there is a substance known as prostatic sand, which is calcified *corpora amyloacea*. The symptoms are:—pain either of a continuous aching type or intermittent. It is referred to the perineum, testicle, inguinal region or tip of the penis. Pain is usually associated with micturition. Hematuria may be present, and is usually terminal. Dysuria, increased frequency of micturition and pyuria and other symptoms associated with prostatitis are also met with in the majority of cases. On rectal examination the prostate may be found to be enlarged, or there may be merely a "lumpiness," together with tenderness. The diagnosis, however, can only be made with certainty by means of X-rays. The author states that if a roentgenogram of the unemptied bladder, exposed with the patient in the level supine or reversed Trendelenburg position, shows a shadow or group of shadows in the region of the neck of the bladder, and a second roentgenogram, exposed with the patient in the Trendelenburg position and the X-rays passing in the same relative direction, shows the shadow in the same place as before, the stone or stones are fixed in the prostate or the prostatic urethra, or in a diverticulum behind the prostate.

(145) Urethral Caruncle.

Urethral caruncles are usually defined as benign neoplasms of an angiomatous nature. J. Welfeld finds that they may be single or multiple; that they may be pedunculated and protrude from the urethra, or broad-based and block the canal almost completely (*Urol. and Cutan. Review*, February, 1917). They are pink to bright red, and bleed very readily. The patients complain of extreme pain on micturition, on walking and during coitus. The diagnosis of the pedunculated variety is easy, but more difficulty may be experienced in recognizing the internal or concealed carunculae. These may be seen by means of a wire speculum or by stripping the urethra. The differential diagnosis has to be made from fibromata of the urethra, which appear in infants and children, are smooth and firm and do not bleed; from polypi and prolapsed mucous membrane, which are less vascular and less sensitive and are not so sensitive. The treatment consists in the removal of the caruncles by means of the galvano-cautery.

British Medical Association News.

MEDICO-POLITICAL.

Meeting of the Federal Committee.

A special meeting of the Federal Committee was held at the B.M.A. Buildings, 30-34 Elizabeth Street, Sydney, on April 25 and 26, 1917. The meeting had been convened at the request of the Victorian Branch for the purpose of considering the question of the staffing of clinics established for the treatment of persons affected with venereal diseases, and for other purposes. The representatives of the several Branches were as follows:—

New South Wales: Drs. G. H. Abbott and David Thomas.
Victoria: Mr. G. A. Syme and General R. H. J. Fetherston.

Queensland: Drs. W. N. Robertson and J. Lockhart Gibson.

South Australia: Drs. F. S. Hone and A. Campbell Magarey.

Tasmania: Drs. A. E. Hayward and D. H. E. Lines.

At the request of the Western Australian Branch the Committee admitted Drs. R. H. Todd and J. Burton Cleland as representatives of that Branch, without the power of voting.

Mr. G. A. Syme was elected to the chair. The Committee elected Lieutenant-Colonel W. T. Hayward Chairman of the Committee, Mr. G. A. Syme Vice-Chairman, and Dr. G. H. Abbott Honorary Secretary.

The Secretary was instructed to send a letter of congratulation to Lieutenant-Colonel W. T. Hayward, to convey to him the goodwill of the Committee.

It was also resolved that a letter be sent to General Sir Alfred Keogh, the Director-General of Medical Services of England, to congratulate him in the name of the medical profession in Australia on the occasion of his having been awarded the Grand Cross of the Bath, a distinction which had not previously been conferred on any member of the medical profession.

It was determined that the letter should be sent to Lieutenant-Colonel Hayward, with the request that he present it personally, as President of the Federal Committee, to General Sir Alfred Keogh.

The Committee congratulated Mr. G. A. Syme on his safe return from active service and on his recovery to health. It congratulated General Fetherston, the Director-General of Medical Services in Australia, on the distinctions gained by him and recorded its appreciation that General Fetherston was present to assist the Committee in its deliberations.

The congratulations of the Committee were extended to Dr. David Thomas, Dr. J. Lockhart Gibson and Dr. D. H. E. Lines on their safe return from active service.

The Committee further determined to send its congratulations to General Sir Neville Howse on the occasion of his knighthood.

Transfer of Membership.

General Fetherston, on behalf of the Victorian Branch, moved the following, which was seconded by Mr. G. A. Syme:—

That (1) when a member leaves a Branch to settle for 12 months at least in another State, the Secretary of the Branch in that State should be informed (a) of the fact, (b) whether his transfer is in order, and (c) the date to which his subscription has been paid.

(2) No medical practitioner shall be received as a member of a Branch until all arrears shall have been paid to the Branch to which he is indebted.

(3) When a member has paid his subscription to one Branch and is transferred before July 1 of that year, one-half of the subscription so received shall be forwarded to the Branch to which he has been transferred.

General Fetherston pointed out that difficulty had been experienced in the past when a member had moved from one State to another, without any notification being received by the Secretary of the second Branch. It was thought that the transfer should not be effected until full particulars were received.

It was pointed out that the Articles of the British Medical Association governed the conditions of membership in a manner which provided for this eventuality. A member became automatically a member of the Branch or Division when he changed his residence to the area of that Branch or Division. It would be *ultra vires* to require any period of residence before the member were received into another Branch.

In view of this explanation, Dr. A. C. Magarey moved and Dr. F. S. Hone seconded:—

That paragraphs (i.) and (ii.) be deleted, and that the following be inserted in their stead:—

That the attention of the Honorary Secretaries and Treasurers of the Branches be drawn to the Articles of the British Medical Association relating to membership.

The amendment was carried and the motion, as amended, was carried as a substantive resolution.

Per Capita Payments by Branches to the British Medical Association.

General Fetherston referred to a message which Dr. W. Kent Hughes had brought from the Manager of the British Medical Association in London concerning the rebate on the money paid by Branches to London in respect of their members. He pointed out that of the sum of 25s., 4s. were returned to the Branches as a grant, and the remainder might be regarded as the members' subscription to the *British Medical Journal*. The cost of production did not amount to this sum, and it was therefore held that it would be reasonable to ask the Council in London to increase the rebate or reduce the amount of subscription payable by the Branches in Australia in respect of their members. He therefore moved:—

That the British Medical Association be approached with a view to securing a reduction of the annual *per capita* payment required to be made by the Branches in Australia in respect of their members.

Dr. W. N. Robertson seconded the motion.

Dr. David Thomas opposed the motion on the ground that the time was unpropitious. He related that the Council of the New South Wales Branch had recently communicated with the Association in London concerning the arrangements which could be made for members absent from Australia on active service. Dr. G. H. Abbott, in response to a question whether this action of the Council of the New South Wales Branch was directed toward securing special treatment for members of that Branch, pointed out that the communication was merely an enquiry in order that they might ascertain what the Association proposed to do in regard to the subscriptions of members on active service. There was no request. He agreed with Dr. Thomas that if their members who were serving the Empire could receive consideration from the Association, it would be unwise to ask for more.

General Fetherston urged that the finances of the British Medical Association were in a satisfactory condition, notwithstanding the war, and suggested that the Association could afford to make a larger rebate.

Dr. David Thomas moved the following amendment, which was seconded by Dr. J. L. Gibson:—

That the action of the Federal Committee in regard to an application to London for a reduction of payments be postponed until the end of the war.

The amendment was carried by five votes to four.

Uniform Medical Registration in Australia.

Dr. F. S. Hone pointed out that the subject of the introduction of uniform conditions of registration of medical practitioners in Australia had been under discussion at the last meeting of the Federal Committee, and had been adjourned. A sub-committee, consisting of Dr. Hayward and himself, had been appointed to draw up a scheme, which had been submitted to the Branches. Replies had been received from the New South Wales, Queensland, Tasmania and South Australia Branches. He emphasized the importance of this matter, not only from the point of view of the persons admitted to the registers in the Commonwealth, but also because difficulty was frequently experienced when a man lived and practised on the border of two States which had different provisions in their Medical Acts. He suggested

that the discussion be postponed until a later time. Subsequently it was resolved that this matter be brought up for consideration at the next meeting of the Federal Committee.

Nationalization of the Medical Profession.

Dr. G. H. Abbott submitted the proposals of the New South Wales Branch Council for a pronouncement in connexion with nationalization of the medical profession. He submitted that these pronouncements, if adopted, would serve as a guide in the formulation of a policy for the Association in Australia.

A spirited discussion followed on the general question. It was pointed out that no one seemed to have a clear conception of the meaning of nationalization of the medical profession. Dr. Robertson related the views of the Labour Party in Queensland concerning this subject. The suggestion was that the members of the medical profession should be salaried and one or more doctors would be told off to give medical attendance to the community in a particular area. No remedy was suggested to relieve a popular man from having more to do than he could manage, while his less popular colleagues would be left with but few patients. He assumed that those practitioners who refused to enter the service of the Government would still have an opportunity of conducting private practice among those people who elected to pay for private attendance. The Labour Party would wish to offer free treatment to all who chose to avail themselves of it.

Dr. F. S. Hone referred to a document which the Federal Committee had drawn up as a reply to certain questions presented to it by the Federal Statistician two or three years before. In this document there was a distinct policy.¹

It was resolved to take the document of the New South Wales Branch Council paragraph by paragraph. The text of the document is as follows:—

(1) That it is in the public interest that the medical profession should consist of a body of men of the highest character and scientific efficiency.

(2) That, bearing in mind that the profession should be composed of persons upon whose wisdom and integrity the community should be able implicitly to rely, the value of the profession to the community depends, for the most part, on the character of its members and upon their efficiency as practitioners.

(3) That, whatever causes or influences operate to make the practice of medicine and surgery less attractive as a career to the highest class of citizens, or to deprive the profession of its freedom or incentive to develop along the natural lines marked out for it by the growth and expansion of scientific knowledge, all such causes or influences are detrimental to the public welfare.

(4) That, generally speaking, the interests of the public are best served by the members of the profession continuing, as at present, to conduct their practices as free individual citizens in competition with one another, subject to the traditional customs and rules of the profession, and under the laws generally governing medical practice in British communities.

(5) That, in certain circumstances, the interests of the community are best served by the creation of medical departments of the public service, as in connexion with His Majesty's Sea and Land Forces, or with the administration of public health, including the superintendence of isolation hospitals for infectious diseases, and of hospitals for the insane, and the systematic inspection of State school children for the detection of their physical defects and latent constitutional disabilities; but that the circumstances, which render such departments necessary and appropriate, are comparatively limited in number and readily recognized.

(6) That any extension of the method, whereby medical attendance, as distinct from administrative departmental work, is supplied to the community through the agency of a State or other Government service, is to be deprecated, as tending to demoralize the recipients thereof, except such extension is made on the ground

that it is expedient to meet the temporary requirements of urgent public necessity.

(7) That, as a general principle, any third party intervention between medical attendant and patient, whether such third party be an individual, a corporate body, or a Government department, is inherently wrong, as being destructive of that relationship, essential in medical treatment, which is based upon the attendant's sense of his personal responsibility for the proper performance of his duty, and the patient's confidence in his attendant's skill and honour.

(8) That the status of medical attendant, as properly understood, is inconsistent with that of Government servant, inasmuch as, in the case of a Government servant,

(i.) the true relationship of medical attendant and patient is non-existent;

(ii.) the medical attendant is compelled, in virtue of his position as the servant of a third party, to surrender his independence;

(iii.) the medical attendant, if not by nature a person unsuited to undertake the grave responsibilities of professional life by reason of his want of initiative, ambition and independence of thought and character, is almost certain to lose the qualities which make for efficiency, owing to the absence of necessity or opportunity for exercising them, and to the inevitable departmental opposition to their free play.

(9) That every step taken by the State in the direction of substituting Government servants as medical attendants in the place of free medical practitioners is to be deprecated on the ground that it will tend to reduce the quality and lower the efficiency of the medical profession, and thereby re-act detrimentally upon the public welfare.

Paragraphs (1), (2), (3) and (4) were agreed to without amendment. On the motion that paragraph (5) be adopted, Dr. F. S. Hone made an appeal in favour of the departmental medical officer. He claimed that with the progress of science and the application of measures for mass amelioration of disease and disability, there must come a vast extension of departmental services. No one could foresee what the future requirements would be in this respect. He did not think that they would be justified in stating that the circumstances which rendered departments of this kind necessary, were limited in number, and he was convinced that they might not be recognized by everyone at a given time.

Some of the members questioned whether it was accurate to make a comprehensive assertion that an extension of the method of supplying medical attendance through the agency of a governmental department tended to demoralize the recipients of the attendance, and a comparison was drawn between the practice of a governmental medical officer and that of a lodge surgeon. Eventually paragraphs (5) and (6) were welded into one in the following form:—

(5) That, in certain circumstances, the interests of the community are best served by the creation of medical departments of the public services, as for instance, in connexion with His Majesty's Sea and Land Forces, or with the administration of public health, including the superintendence of isolation hospitals for infectious diseases, and of hospitals for the insane, and the systematic inspection of State school children for the detection of their physical defects and latent constitutional disabilities, but that extension of the method, whereby medical attendance, as distinct from administrative departmental work, is supplied to the community through the agency of a State or other Government service, is to be deprecated, as tending to demoralize the recipients thereof, except such extension is expedient to meet temporary requirements of urgent public necessity.

Dr. Gibson was of opinion that there was little, if any, difference between third party intervention between the medical attendant and the patient in the case of a State medical service or in the case of lodge practice. The question was raised whether there was actually any third party intervention in the case of the military service, such as would disturb the relations between the military surgeon

¹ This document does not refer to a scheme of nationalization of the medical profession, but was drawn up in reference to a scheme of national sickness insurance.—Ed.

and his soldier patient. The members admitted that the medical service given by the medical officers of the Army Medical Corps had been of the greatest value, not only to the nation, but also to the men as individuals. Dr. Hone spoke of the service of the Government Medical Officer in tending the poor, and maintained that in his own experience there was no essential difference between this and private practice. In regard to Lodge practice, to which reference was made, the majority of the members expressed the view that it was not a desirable arrangement, although they recognized it as necessary. There was general agreement on the main principle involved, and the paragraph was adopted after amendment as follows:—

(6) That, as a general principle, third party intervention between medical attendant and patient, whether such third party be an individual, a corporate body, or a Government department, is liable to destroy that relationship, essential in medical treatment, which is based upon the attendant's sense of his personal responsibility for the proper performance of his duty and the patient's confidence in his attendant's skill and honour.

Dr. Hone submitted that paragraph (8), as far as he could understand it, was illogical. He held that there was no argument in favour of the first statement that the status of medical attendant was inconsistent with that of a Government servant. Moreover, he asked what was the status of the medical attendant, "as properly understood." He commented on the assertions that in the case of a Government servant the true relationship of medical attendant and patient was non-existent. It might be so, but he contended that the rule was by means invariable, and he was equally emphatic in denying the allegation that the medical attendant under these circumstances was bound to surrender his independence. He instanced cases in which a Government medical officer has held his ground in the face of interference of the department, and spoke of instances in which the department did not interfere in the least with the medical officer in the conduct of his practice.

Dr. Robertson related the case of a medical officer who had resigned because he objected to obey the ruling of his department.

Dr. Abbott suggested that if it were necessary for the officer to resign, it was obvious that he would have to surrender his independence as long as he remained in the service of the department. Several members expressed the opinion that the meaning of the sub-clause (iii.) was so involved that they did not understand it. It was proposed to get rid of the double negation, but Dr. Abbott pointed out that the sense would be altered by this. On being put to the vote, the whole paragraph was rejected.

Paragraph (9), which thus became (7), was approved.

On the motion of Dr. Abbott, seconded by Dr. D. Thomas, it was resolved:—

That the proposals for a pronouncement *re* nationalization of the medical profession, as amended, be adopted.

In the course of the final discussion, Dr. G. H. Abbott urged that a beginning should be made to formulate a policy. Dr. Robertson had told them what the proposals of the Labour Party in Queensland were. In other States there were indications that some similar scheme might be introduced, and it was therefore a matter of urgent necessity for them to be prepared for any emergency.

Dr. Gibson thought that it would be well to let the Labour Party know their views. He referred to the experience the profession had made in Queensland in connexion with the Opticians' Bill. The Minister had told them that the medical profession had not raised any protest against its passage—"had not raised a single squeak." He held that Lodge practice was not parallel to nationalization. In Lodge practice the members, through their Committee, selected their attendants. He wished to drive it home to the Labour Party that any proposal which would injure the medical profession must of necessity also injure the general community. The scheme of nationalization of the medical profession would certainly injure both.

General Fetherston informed the Committee that the Government in Victoria had given the doctors a definite promise to consult the profession before any legislations

involving nationalization or national insurance were introduced. He held that there was a certain amount of difference of opinion among the members of the profession concerning these proposals. He pointed out that national insurance has received the approval of a large section of the medical profession in Great Britain, and had certainly worked well.

Dr. J. B. Cleland intimated that the members of the Western Australian Branch had agreed with the New South Wales Branch, and wished to record their approval of the principles contained in the document under discussion.

Dr. David Thomas called General Fetherston's attention to the fact that, while national insurance in Great Britain has undoubtedly benefited the pocket of the medical profession, the fact that some men had 2000 insured persons on their lists and more indicated that the benefit did not extend to the community. In the long run, if the work were done as badly as it was being done at the present time, national insurance would prove itself to be the worst event that had occurred to the medical profession during the last 25 years.

Dr. Gibson and Dr. Hone both agreed that a limit should be put on the number of persons on any one practitioner's list.

Mr. Syme was not convinced that a salaried medical officer did his work less efficiently than a private practitioner.

It was resolved that copies of the resolutions be sent to each Branch for consideration and report to the next meeting of the Committee, and that the attention of the Branches be drawn to a document entitled "Replies from the Federal Committee of the British Medical Association in Australia to the queries of the Federal Statistician."

The motion was seconded by Dr. David Thomas and carried.

Venereal Diseases.

Dr. F. S. Hone moved that item C.1, (c) standing on the agenda paper under the name of the New South Wales Branch be taken first. Dr. Abbott therefore moved that the recommendations contained in the report of the Council of the New South Wales Branch on the report of the Committee of the Trade and Customs Department, on the Causes of Death and Invalidity in the Commonwealth, dealing with Venereal Diseases, be adopted by the Federal Committee. The recommendations have reference to the recommendations of the Departmental Committee's report (see *The Medical Journal of Australia*, October 21, 1916, p. 346).

1. Educational. This recommendation was approved.

In the course of a short discussion on the subject of the education of children in connexion with continence and the necessity of the avoidance of promiscuous sexual intercourse, it was resolved that Drs. Gibson and Robertson be asked to draw up a pamphlet dealing with this subject to be submitted to the Federal Committee at its meeting in February, 1918.

2. Provision of means of diagnosis and treatment. This recommendation was approved, but was subsequently amended on the motion of Dr. J. Burton Cleland. Dr. Cleland called attention to the fact that the Wassermann test needed special care and knowledge in its application, and that it should not be entrusted to unqualified individuals. In some laboratories the work was handed over to the laboratory attendant. In the view of the Western Australian Branch the only persons competent to carry out this and similar laboratory work was a medical practitioner, or a graduate in science or veterinary science who had had training in bacteriology. He felt that the wording "entrusting of the Wassermann test to specialists in approved laboratories" might be regarded as sanctioning the practice of allowing the attendant to carry out the test. He moved that the clause be amended to read:—

(1) For full provision for assistance in diagnosis by laboratory methods and for the Wassermann test to be carried out under the direct supervision of specialists in approved laboratories.

General Fetherston referred to some experiments by a laboratory attendant in one of the military hospitals in Victoria. The man had come from New South Wales and was not a registered medical practitioner.

The arrangement had worked badly. He asked Dr. Cleland whether he had come from his laboratory. Dr. Cleland replied that he had not. None of the attendants in the Microbiological Laboratory were permitted to carry out the Wassermann test, except under the direct supervision of himself or one of the other medical officers. The amendment was carried.

Dr. Gibson favoured free treatment for all, in order that everyone should be treated, but did not press the point. The recommendation 2, as amended, was approved.

3. Provision for Seamen. This recommendation was approved.

4. Regulation of prostitution. This recommendation was approved.

5. Special legislation. The Committee approved the main propositions, numbered 1 to 13 in the report of the Departmental (Trade and Customs) Committee, which embodied the main provisions of the Western Australian Health Act.

Dealing with the recommendations concerning the proposals for additional legislation, the Committee was in accord with the New South Wales Branch save in regard to suggestion (1.).

Dr. J. L. Gibson stated that it was provided in the Queensland Act that a communication to the effect that a patient was suffering from venereal disease in an infectious stage made to the person to whom the patient was about to be married, was privileged, if the patient persisted in his intention to marry, notwithstanding the warning of the medical attendant. He held very strongly that it was the duty of the doctor to prevent the marriage of an infected person in the interest of the other party. It would be of greater value if the information could be given at once to the police, in order that the patient might be apprehended before he has infected his bride. As this would be attended with some difficulty it would perhaps meet the case if the communication should be made to the Commissioner of Health.

Mr. G. A. Syme raised the question whether it would be possible to introduce this provision in the regulations of the Victorian Act. The difficulty was that unless restraint was imposed on the patient rapidly, the harm would be done before the police has time to act. The Committee resolved to adopt the recommendation of the Trade and Customs Departmental Committee, as follows:—

1. To provide that if an infectious patient persists in the intention to marry, despite the warning already alluded to, a communication made *bonâ fide* by the medical practitioner in attendance to the person to be married or to the parent or guardian of such person shall be privileged. The existence of such privilege would probably make such disclosure unnecessary. We are not in favour of requiring a clean medical certificate from both parties before every marriage.

6. National insurance. This recommendation was approved.

7. The sale of alcohol. This recommendation was approved.

8. Research. This recommendation was approved.

9. Responsibility and Finance. It was pointed out that Victoria, Queensland, Western Australia and Tasmania had signified their willingness to adopt the suggestions of the Federal Government, and would receive the contribution promised. The recommendation was approved.

The motion that the recommendations as amended be adopted was carried.

On resuming on April 26, Dr. W. N. Robertson moved:—

That it be a recommendation to the Queensland Branch to ask the Government to amend Section 11 (8) of the Health Act (Amendment) Act, 1917, by the addition of the words: "and/or to the proper health authority" after the words "officer of police."

He spoke of an instance in which a patient of his had announced his intention of marrying on the following day despite the fact that he was suffering from venereal disease, and despite the warning he had given him. He had been powerless to prevent the marriage. The new Act now permitted him to disclose the fact to the person about to be married to the patient or her parents. It would be a distinct advantage if this information could be given to the Health Commissioner.

Dr. Gibson seconded the motion, which was carried.

Dr. David Thomas moved and Dr. W. N. Robertson seconded:—

That it be a recommendation to the Victorian, Tasmanian and Western Australian Branches to ask the State Governments to introduce a clause similar to Section 11 (8) of the Health Act (Amendment) Act, Queensland, 1917, with the addition of the suggested amendment.

The motion was carried.

Dr. David Thomas moved and Dr. W. N. Robertson seconded:—

That it be a recommendation to the New South Wales and South Australian Branches to ask that the State Governments be approached with a view to having a Venereal Diseases Act passed on similar lines to the Acts of Western Australia, Queensland, Victoria and Tasmania.

The motion was carried after a short discussion.

General Fetherston regretted that the proposals did not include a recommendation for the general adoption of preventive measures against infection. These measures had been adopted freely in the Army, and had been the means of preserving the health of a large number of men. From the point of view of public health, they were to be recommended, as the best means of checking the spread of infection. In the Army there was no compulsion, but every man was advised to adopt or have adopted for him precautionary measures should he expose himself to infection.

Dr. F. S. Hone held that it would be quite illogical to teach preventive measures, after having determined that sexual intercourse was neither necessary nor beneficial to health. Counsel of this kind would alienate public sympathy from them and impede their efforts to combat venereal diseases.

Dr. J. L. Gibson maintained that there was only one preventive to venereal diseases, and that was abstinence from illicit sexual intercourse. He opposed the application of preventive measures, which did not even have the advantage that they were infallible, to the community, although he recognized that their application in the case of soldiers was a matter of expediency.

After some further discussion, General Fetherston moved:

That it be a recommendation to the Branches to consider the question whether precautions for the prevention of venereal diseases which should be taken by those who had exposed themselves to the risk of infection should be made more widely known.

The motion was carried.

Dr. G. H. Abbott read a letter from the Council of the Victorian Branch dealing with the question of the advisability of public venereal clinics being conducted by whole-time salaried Government medical officers. The Victorian Branch had considered this matter in connexion with the Venereal Diseases Act, and had opposed the proposition. Dr. Abbott also read a resolution that had been passed by the Council of the New South Wales Branch as an instruction to its representatives on the Federal Committee.

Dr. F. S. Hone moved that the resolution of the Council of the New South Wales Branch to the following effect be adopted by the Federal Committee:—

That the Federal Committee is of opinion that wherever venereal clinics are established (a) they should be in connexion with, and under the direct control of, the public general hospitals, and not institutions directly administered by a Government department; and, (b) they should be directed by an honorary medical staff.

The motion was seconded by Dr. H. E. Magarey and was carried.

(To be Continued.)

A meeting of the Council of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on April 12, 1917, Professor R. J. A. Berry, the President, in the chair.

The attention of the Council was occupied for a considerable time in connexion with a matter of medico-ethical importance.

Dr. M. E. Lynch, the Secretary of the Ophthalmological section, was present by invitation, for the purpose of ex-

plaining the ground on which opposition to the proposed lowering of the standards of vision for sea pilots was based. It was resolved that a deputation of the whole Council should wait on the Chief Secretary on April 17, 1917, to protest against a lowering of the standard.

The Sub-committee appointed to consider the advisability of the Council undertaking the work of a medical agency submitted its report. After a full discussion, it was resolved by a large majority that a medical agency should be established under the control of the Medical Society of Victoria; that the Medical Agency should be conducted by Mr. C. Stanton Crouch, with the supervision of a small honorary sub-committee, appointed by the Committee of the Society. It was further resolved that any profits of the medical agency business should be paid into the funds of the Medical Society of Victoria.

The Honorary Secretary reported that the Honorary Secretary of the Friendly Societies' Association had sent a reply to the Council's request that a conference be arranged for the purpose of renewing the negotiations. The reply was to the effect that the Friendly Societies' Association regarded it undesirable to have a conference at the present juncture. To this letter a reply had been sent, intimating to the Friendly Societies' Association that any delay in the re-opening of negotiations would be regarded as an unfriendly act.

The Council instructed the Honorary Secretary to send letters of sympathy to the relatives of the late Captain H. B. Hughes, who had been killed in action, and to the widow of the late Dr. M. A. Reid. They also determined that a letter of congratulation be forwarded to Captain Harrie B. Lee, on his having been awarded the Military Cross for bravery.

It was decided to ask the Editor of *The Medical Journal of Australia* to open a fund in aid of Lady Stanley's appeal for assistance to the Red Cross funds.

A meeting of the Council of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on April 25, 1917, Professor R. J. A. Berry, the President, in the chair.

The President reported that a conference had been held with the representatives of the Pharmaceutical Society, and that important decisions in regard to ethical principles, and the limitations of the respective spheres of doctors and pharmacists had been arrived at. These decisions would be considered at a subsequent meeting of the Council.

The President also reported that a deputation had waited on the Chief Secretary for the purpose of laying before him the views of the medical profession on the question of the standard of vision of sea pilots, and that the result of their representation had been eminently satisfactory.

The suggestion to the President and the Council that post-graduate classes should be established at the University, was referred to the Scientific Committee for report.

A discussion was held on the proposal to cause the publication of a card index of all medical literature of the various medical libraries in the State. The President was authorized to lay the matter before the professional Board of the University, with a view to obtaining State assistance in the compilation of the index.

It was resolved that an Executive Committee be appointed for the purpose of dealing with routine business. The two Vice-Presidents and the Honorary Secretary would act as this committee. The object was to lighten the labours of the full Council at its meeting. The Committee was given power of co-option for special purposes.

The Honorary Secretary was instructed to address a letter of condolence to Colonel J. W. Barrett on the loss of his son, Lieutenant Keith Barrett.

The Council considered various details in connexion with the establishment of a medical agency, and approved a circular for issue to members, subject to modification, if found necessary.

Dr. A. E. Rowden White tendered his resignation as a member of the Council, as he had been accepted for military service abroad. The Council accepted the resignation with regret. Dr. J. R. Davis was elected to the vacant position.

Dr. Alex Lewers gave notice of the following motion:—

That regulations 1-2, under "trade advertisement," be amended as follows:—

After the words "no member engaged in medical practice" insert "or who holds a salaried position by virtue of a medical or surgical qualification."

The motion will be discussed at the meeting of the Branch on June 6, 1917.

Donovan Sylvester Foy, M.B., Ch.M., 1916 (Univ. Sydney), of the Mater Misericordiae Hospital, North Sydney, has been nominated for election as a member of the New South Wales Branch.

Arthur Christian Holt, M.B., 1901 (Univ. Sydney), of Copeland Street, Beecroft, has been elected a member of the New South Wales Branch.

Special Correspondence.

(By Our Special Correspondent.)

LONDON LETTER.

War Congress of Dental Surgeons.

A dental congress under the recognition of all the Allied Governments was held in Paris early in November, to consider the treatment of difficult face and jaw wounds and the restoration of damaged parts. Delegates and representatives from Allied Governments and National Red Cross Societies attended, as well as several Army dental surgeons from the British base hospitals in France. A party of civilian dental surgeons holding military consultative appointments and members of the staff of the Red Cross Hospitals for treating facial wounds were granted facilities by the military authorities to attend the meeting. A large number of specimens and exhibits were shown and information derived from actual experience was contributed by the various delegates. Several hospitals offering special treatment for those wounded in the face, among them that of the American Ambulance at Neuilly, were visited in Paris.

King Edward's Hospital Fund.

Viscount Iveagh presided over a meeting of the Governors and General Council of King Edward's Hospital Fund at St. James's Palace on December 15, 1916.

He read to the meeting the following letter from the King: Buckingham Palace,

December 12th, 1916.

I am commanded by the King, Patron of the Fund, to ask you to convey to the Council of King Edward's Hospital Fund at their meeting on the 15th inst. his congratulations on the distribution of £170,000 this year. This, as his Majesty reminds you, is £30,000 more than last year's total, and £12,500 over the previous record achieved in the years just before the war.

The King is much gratified at this evidence of the power of the Fund to give substantial assistance to the Hospitals in a time of exceptional difficulty. He trusts that the public will help to maintain this record, and he hopes especially that there may be an increase in the ranks of annual subscribers, whose numbers are naturally depleted from various causes each year.

His Majesty learned with much regret of the death of Mr. Algernon Sydney, who had done such good service to the Fund for many years; and he takes this opportunity of conveying to the Governors, Council, Officers and all Committees of the Fund, as well as to the Visitors, his cordial appreciation of their work for the Hospital Service, now more important than ever to the welfare of his people.

—Yours very truly,

STAMFORDHAM.

Lord Revelstoke, the Honorary Treasurer, said that the net receipts for the year to December 11, 1916, apart from receipts on capital account, had amounted to £269,526 18s. 6d. This included £100,000 cash received from Sir Walter Trower in respect of the residue of the estate of the late Isabella, Countess of Wilton, and the Fund had already had

transferred to it securities amounting to over £22,000. The Finance Committee were retaining the cash uninvested, so as not to hamper in any way the discretion of the Council in deciding as to the use of the money in the event of any emergency.

Sir William Collins announced, on behalf of the League of Mercy, for the fourth year in succession, a grant of £14,000 to the Fund.

Reports were presented from the Distribution and the Awards Committees.

The adoption of the report was moved by Lord Iveagh and seconded by the Duke of Norfolk.

In replying to a vote of thanks for the occupancy of the chair, Lord Iveagh said:—

Ours is essentially a work of peace, but I fear many anxious months must pass before peace and its blessings again visit our land. Peace will lessen some of the difficulties under which we are working, but I foresee as one of the results of the hardships and privations of our men in the field, hardships and privations borne so nobly and uncomplainingly, a heavier load even than before will be thrown upon the resources of the hospitals when these gallant men return to civil life. For in many of them, fighting at the various seats of war, will be sown with the seeds of future ills, and it behoves us to continue untiring in our efforts to increase, if possible, the resources of the Fund, instituted through the far-seeing sagacity of King Edward, and in which King George continues to take such a deep and encouraging interest.

The Lady Doctor.

At a meeting held to celebrate the jubilee of the New Hospital for Women on December 12, 1916, Sir John Bland Sutton, in the course of a congratulatory address, said many people imagined that when a new hospital opened its doors it was sure to be crowded with patients. No such thing; hospital patients were curiously discriminating. They select their hospitals with the same shrewd judgement that they chose a theatre. As with theatres, so with hospitals. If good work was done in a hospital the wards would be filled and the waiting list a long one. On several occasions he had collected the annual reports issued by some of the large London hospitals and compared the results of the gynaecological operations with those obtained at the New Hospital for Women. The latter were equal to any, and beaten by none. Opportunities for clinical work were essential for all who wished to become physicians and surgeons. To give women sufficient opportunities for clinical work was one of the great reasons that led to the foundation of the New Hospital for Women. It might have been sufficient at the time it was built; not so now. Not only must the Hospital be maintained at its full capacity, but a wider field was needed. The strain thrown upon the medical profession by the war had emphasized the usefulness of medical women. Never before had they had such an opportunity of demonstrating their capability in the domain of medicine and surgery. Some of the London medical schools were considering the necessity of widening their doors for the admission of women to full curriculum. He maintained that the great hospitals of London, which were the glory and the pride of Great Britain, should be opened to medical women on the same terms as for men. To-day medical women, undaunted by the difficulties of the past, were accomplishing things unimagined by their predecessors. Medical women had fought a hard fight against public prejudice and professional bias, and were steadily softening and moulding public opinion.

Correspondence.

THE MEDICAL PROFESSION AND THE WAR.

Sir,—I notice, both in the lay press and in your journal, the constant call for medical men for active service. How can the Defence Department expect married men with families, practices, and other large responsibilities, to go out on active service on a captain's pay, while other

younger, unmarried men, without established practices and with no responsibilities, are enlisted and kept at home in safe, comfortable positions, often carrying the rank and pay of a major. One reads repeatedly of doctors who have been killed on active service—men who gave up everything—who left family, practice, and other interests—and who have now laid down their lives for their country's welfare. Contrast the records of these men with that of the "patriots," eligible in every respect for active service, who for "King and country" enlist for home service, because they can make more financially in that way than in private competition with their fellow medicos. It is unfortunate that the Defence Law of this country leaves room for shirkers, medical or otherwise; but that the Defence Department should shelter them under a red-tabbed uniform is an injustice which calls loudly for elimination. When the Department and the public generally awake to a sense of this injustice, the call for medical men will probably meet with a more ready response.

Yours, etc.,

DOCTOR'S WIFE.

Melbourne, May 4, 1917.

VISION OF PILOTS.

Sir,—I do not know the exact standard of vision required by the Victorian Pilot Service, but I know it is a high one.

It is surely a matter for congratulation that eyes are at last to be scientifically examined by competent persons, and not left to the tender mercies of the comparatively untrained. Slipshod methods have been in vogue too long, and it is high time they were relegated to the limbo of obscurity.

Dr. Bickle complains that a certain candidate, who presumably had normal vision, was "turned down" because he had a "small amount of hypermetropia." If a man is to have normal vision at 50 years of age, without glasses, then he must not possess this "small amount of hypermetropia." Is it not better, in every way, particularly for the man himself, to be rejected when young, and able to take up some other calling, than to let him spend the best years of his life working his way up in the service, and then to be retired at 45 or 50, when too old to start some other avocation, because he no longer possesses normal vision without glasses, his "small amount of hypermetropia" having meanwhile become manifest? That this man was accepted by one of the "biggest companies" and "passed the naval examination," shows these bodies are concerned only in the present; are going to take the best out of the man, and when no longer possessing normal vision turn him aside as unfit. The V.P.S., by thinking of the future, is more humane and is taking fewer risks. The surgeon who proposed this thorough examination to the V.P.S. deserves the thanks of the community. It will not be long before "the biggest companies" and the Navy will be adopting the same course; they will then find an examination of the refraction and the *fundus oculi* tell them more than is dreamt of in their philosophy.

Yours, etc.,

SAML. H. HUGHES.

173 Macquarie-street, Sydney,
May 4, 1917.

GALYL

Sir,—Would you kindly give me the answer to following: In using galy I found an insoluble residue left after adding to boiling or warm water. In this respect galy is not nearly as satisfactory as neosalvarsan. The latter dissolved completely almost at once. In the pamphlet on galy you are advised, failing complete solution, to add NaOH solution drop by drop. I find the insoluble residue can also be got rid of by bringing solution to or near boiling point, but the solution then becomes cloudy, instead of remaining clear. The question I wish to ask is, does the heating process, to dissolve completely, have any injurious action on the galy; does it partly or wholly decompose it, and render it useless? If not, it seems preferable, as it is easier to use, and gives the less danger of adding just a little too

much caustic solution. This point is not referred to in pamphlet.

Yours, etc.,

G. S. THOMPSON.

Sydney, May 3, 1917.

[Dr. Thompson will be well advised if he avoids heating a solution of galy for the purpose of obtaining complete solution. The appearance of cloudiness indicates some dissociation of the compound. It has been found that all arsenobenzol compounds are altered when subjected to high temperatures, and should therefore not be heated beyond 37°-38° C. The undissolved residue is usually composed of relatively large crystals which dissolve but slowly. The addition of two or three drops of a decinormal solution of sodium hydrate is quite safe, and accelerates the solution of undissolved crystals. In view of the fact that the amount of galy remaining undissolved when the instructions are carried out with care, is relatively very small, it is really immaterial whether the residue be dissolved or not.]

Medical Appointments.

Dr. J. E. F. Stewart has been appointed Medical Officer of Health for Midland Junction, Western Australia.

Dr. Hugh Stanislaus Bourke has resigned his position as Public Vaccinator for the South-Western District, Victoria.

Dr. William George Henry Cuscaden has been appointed Officer of Health at South Melbourne City, in place of Dr. T. J. W. Kenny.

In the Bet Bet Shire, Victoria, Dr. Arthur Albert Crooke has been appointed Officer of Health for Dunolly and Bealiba Ridings and Dr. Alan Bothwell McCutcheon for Borough and Tarnagulla Ridings.

Dr. John Krueger Kelmar has been appointed Officer of Health for the Central, West and North Ridings, Shire of Kowree, Victoria.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xv.
Atherton District Hospital, Medical Officer.
Brisbane Hospital, Junior Resident Medical Officers.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

| Branch. | APPOINTMENTS. |
|---|---|
| TASMANIA. | |
| (Hon. Sec., Bel- lerville, Tasmania.) | Honorary Medical Officers in all State- aided Hospitals in Tasmania. |
| VICTORIA. | |
| (Hon. Sec., Medi- cal Society Hall, East Melbourne.) | Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australian Prudential Association Pro- prietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club. |
| QUEENSLAND. | |
| (Hon. Sec., B.M.A. Building, Ade- laide Street, Bris- bane.) | Medical Officers to the Selwyn Hos- pital, North Queensland. Brisbane United Friendly Society In- stitute. |

Branch.

SOUTH AUS- TRALIA.

(Hon. Sec., 3
North Terrace,
Adelaide.)

WESTERN AUS- TRALIA.

(Hon. Sec., 230
St George's Ter-
race, Perth.)

APPOINTMENTS.

The F.S. Medical Assoc., Incomp.,
Adelaide.

Swan District Medical Officer.
All Contract Practice Appointments in
Western Australia.

Department of Public Instruction—Ap-
pointments as Salaried Medical
Officers, with duties which include
the treatment of school children.
Australian Natives' Association.
Balmmain United F.S. Dispensary.
Canterbury United F.S. Dispensary.
Leichhardt and Petersham Dispensary.
M.U. Oddfellows' Med. Inst., Elizabeth
Street, Sydney.
Marrickville United F.S. Dispensary.
N.S.W. Ambulance Association and
Transport Brigade.
North Sydney United F.S.
People's Prudential Benefit Society.
Phoenix Mutual Provident Society.
F.S. Lodges at Casino.
F.S. Lodges at Lithgow.
F.S. Lodges at Parramatta, Penrith,
Auburn and Lidcombe.
Newcastle Collieries — Killingworth,
Seaham Nos. 1 and 2, West Wall-
send.
Metropolitan Colliery, Helensburgh.

NEW ZEALAND: WELLINGTON DIVISION.

(Hon. Sec., Wel-
lington.)

Friendly Society Lodges, Wellington,
N.Z.

Diary for the Month.

May 12.—S. Aust. Branch, B.M.A., Council.
May 15.—N.S.W. Branch, B.M.A., Executive and Finance
Committee.
May 16.—W. Aust. Branch, B.M.A., General.
May 16.—Western Suburbs Med. Assoc. (N.S.W.).
May 18.—Q. Branch, B.M.A., Council.
May 18.—N.S.W. Branch, B.M.A. (Branch, Extraordinary).
May 25.—S. Aust. Branch, B.M.A., Branch.
May 25.—N.S.W. Branch, B.M.A., Branch (Ordinary).
May 25.—S. Aust. Branch, B.M.A., Branch.
May 25.—N.S.W. Branch, B.M.A., Branch, Ordinary.
May 29.—N.S.W. Branch, B.M.A., Med. Politics Committee;
Organization and Science Committee.
May 30.—Vic. Branch, B.M.A., Council.
June 1.—Q. Branch, B.M.A., Branch.
June 6.—Vic. Branch, B.M.A., Branch.
June 8.—N.S.W. Branch, B.M.A., Clinical.
June 9.—S. Aust. Branch, B.M.A., Council.
June 12.—Tas. Branch, B.M.A., Council and Branch.
June 12.—N.S.W. Branch, B.M.A., Ethics Committee.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any
circumstances be returned.
Original articles forwarded for publication are understood to be offered to
The Medical Journal of Australia alone, unless the contrary be stated.
All communications should be addressed to "The Editor," The Medical
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New South Wales.